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to the EMCDDA

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Pathways through treatment



On 25 January 2016 Coolmine Therapeutic Community (CTC) published the results of a longitudinal outcomes study *Pathways through treatment: a mixed-methods longitudinal outcomes study of Coolmine Therapeutic Community*.¹ The key finding of the study is that, despite the many instances of relapse, the positive impact of all CTC programmes on clients is undeniable.

Overall, substance use declined, physical and mental health improved, and clients demonstrated improvements with regard to housing, employment, education and family relationships.

Prof Catherine Comiskey,
Amy Blake (Acting CEO Coolmine
Therapeutic Community),
Minister for Health Leo
Varadkar and Alan Connolly
(Chairman Coolmine Therapeutic
Community) attending the launch
of Coolmine's longitudinal
outcomes study

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In brief

Tackling the harm caused to individuals and society by the misuse of drugs is the overall objective of the National Drugs Strategy. Preventing drug-related deaths is the most obvious and pressing part of the work guided by this objective. The EMCDDA estimates that there were at least 6,800 overdose deaths in the European Union in 2014. Opioid users, particularly those who inject drugs, are at particular risk. The growing number of deaths among older drug users reflects the ageing nature of the opioid-using population.

This issue of *Drugnet Ireland* looks at several recent Irish and international studies which examine both the factors contributing to death among heroin users and the measures being taken to reduce the risk of death.

Participation in opiate substitution treatment (OST) is known to reduce mortality among this group of drug users, particularly among those who inject. Risks remain, of course, for those in OST such methadone maintenance treatment. One of the studies looked at in this issue identified a significant association between risk of mortality and imprisonment, medical issues and engagement with treatment. The association between engagement in treatment and risk of death, from both poisoning and non-poisoning causes, is the specific focus of another study described in this issue, whose findings strengthen the evidence on the dangers of leaving OST.

Drug-related deaths data also provide information about the circumstances in which a person dies, and the knowledge that a large number of those who die from an overdose are not alone at the time of death suggests that some of these deaths may be avoidable. It is known that naloxone can reverse respiratory depression and a recent EMCDDA study covered later in this issue synthesises recent evidence around the efficacy of take-home naloxone.

These studies demonstrate how innovative use of data gathered through routine monitoring, together with data held in prescription and other medical recording systems, can provide valuable insights into both the factors contributing to mortality and the means to prevent it.

Pathways to treatment continued

The primary aim was to track CTC clients over two years, gathering data on treatment retention, substance use, physical and psychosocial health, social functioning and criminal activity. The study also aimed to compare outcomes for clients of CTC's three treatment programmes – male residential (the Lodge), female residential (Ashleigh House) and the mixed-gender drug-free day programme (DFDP).

Method

The mixed-methods study included quantitative information on 144 participants, and 86 qualitative interviews with 28 participants, which allowed for in-depth exploration of issues.

Quantitative data collection commenced in February 2011 with interviews taking place at baseline and at six-monthly intervals over the next two years. At baseline, the 144 participants recruited to the study were entering a primary treatment service at Coolmine Therapeutic Community. Qualitative interviews also took place at six-monthly intervals, starting in March 2011 and continuing for two years.

Qualitative data were collected from voluntary participants ranging in age from 20 to 47 years through semi-structured interviews at six-monthly intervals. The average of those in this sample was 32 years. CTC's three primary treatment programmes were almost equally represented in this sample, 16 (58%) of whom were male and 12 (42%) female. While 86% of participants reported opiates as their primary problem drug, poly-drug use was common.

Findings

The study found an improvement in nearly all measured outcome areas over the two years of the study. Some programme-based and gender-based differences in treatment pathways, experiences and outcomes were uncovered.

Treatment retention, substance use and outcomes

At treatment intake all 144 participants were actively engaged in one of CTC's three programmes. At the final 24-month data collection phase, 77.1 per cent (n=111) were retained in the study, and of these, 72 per cent (n=80) were reported to be drug-free. Thirty-six per cent of this final sample (n=40) had graduated from their programmes, and 85% (n=34) of these reported being drug-free at 24 months. In other words, the number of clients reporting drug-free status was approximately double that of those who graduated.

The proportion of participants who reported using illicit drug use in the 30 days preceding data collection fell from 43.1 per cent at baseline, to 35.5 per cent at one year and 27.9 per cent at two years. This relapse rate was relatively low compared to rates reported in a recent (2013) systematic review of therapeutic communities (25%–55%).

Graduation rates varied by programme – from 26.7% (n=8) for female residential clients (Ashleigh House), to 36.5% (n=19) for male residential clients (The Lodge), to 50% (n=9) among those on the drug-free day programme (DFDP).



Minister Leo Varadkar and Mr Alan Connolly (Chairman Coolmine Therapeutic Community) at the launch of Coolmine's longitudinal outcomes study

Self-discharges were highest among residential women (53.3%, n=16), next highest among clients of the DFDP (44.4%, n=8), and noticeably lower among male residential clients (21.2%, n=11). However, discharge owing to violation of a CTC protocol was highest among residential men (28.8%, n=15).

The authors comment that it is not clear to what extent women discharged early owing to the apparent lack of community cohesion and general incompatibility with key treatment elements in Ashleigh House (see below under Quality of Life), or owing to their own personal circumstances such as family obligations or psychological needs. The authors suggest these factors were in all likelihood interdependent.

The authors highlight how the circumstances surrounding an individual's entry into treatment influenced the treatment outcome – whether the entry was 'self-motivated' (the client decided individually and autonomously to enter treatment), 'incentivised' (the client entered following a negotiated, suspended prison sentence), or a combination of the two (the client was self-motivated to achieve abstinence but also faced tangible external pressure to comply with treatment). Those who had expressed high levels of self-motivation from the outset were more engaged with the therapeutic programme than those who entered out of a sense of obligation or pressure (i.e. incentivised clients), and this disparity became more apparent as time went on.

The authors also report that motivation was noticeably stronger among clients on the drug-free day programme than clients on the residential programmes. Clients on the day programme reported entering after completing a separate residential programme; they were thus entering treatment after a period of sobriety and with previously acquired knowledge of treatment programmes. In addition, as the day programme was an optional extra after the residential programme, these clients tended to be highly committed to actively practising recovery.

Pathways to treatment continued

Physical health and psychological health

Although women's physical health, mental health and self-reported well-being were all lower than men's on entry to treatment, the mean physical health scores of both increased (males: 11.62 at baseline to 14.49 at two years; females: 10.28 at baseline to 13.05 at two years), as did the mean psychological health scores of both (males: 11.43 at baseline to 12.97 at two years; females: 9.6 at baseline to 13.18 at two years).

The participant interviews reflected the quantitative findings. While many reported on-going health problems, including serious and chronic co-morbidities such as HIV and hepatitis C, most who remained drug-free in their final interview reported that their physical health was markedly improved. Positive mental health was often reported as having to be actively maintained, e.g. through participating in fellowship meetings or adhering to a structured daily routine. Female participants were more likely than males to report mental health issues, such as periods of depression, anxiety, self-harm, suicide ideation and suicide attempts.

Quality of life

The mean quality of life score showed a similar upward trend for both men and women (males: 11.62 at baseline to 13.91 at two years, females: 10.29 at baseline to 13.36 at two years). Improvement in overall quality of life was also reflected in the qualitative data. However, while engaged with CTC, men and women seem to have responded differently to some elements of the therapeutic programme.

Broadly speaking, men responded positively to group living, including the communal residential spaces, the shared chores, and the group therapy. Several of the women, however, struggled with the group element of residential treatment including the group chores and group sessions. Some of the women who had their children with them in Ashleigh House reported that they felt detached from the group-treatment experience, particularly unstructured group time, when compared to those who did not have children in residence with them, as they struggled to balance parenting and participation.

Housing

The proportion of participants reporting acute housing difficulties rose from 21.7 per cent at baseline to 22.8 per cent at two years. According to the authors, this increase may have been related to the fact that many clients at intake were engaged in CTC or another formal treatment service and were not experiencing acute housing problems. The majority of participants who were interviewed reported relying on housing services for assistance in securing housing and many found clean, safe and comfortable places to reside. But for some, owing to prior periods of homelessness and incarceration, the experience was challenging and far more precarious.

Education and employment

Both male and female clients were distinctly more active in their attempts to engage with education and the labour market after engaging with CTC. The proportion engaged in paid employment increased from 3.5 per cent at intake to 25 per cent at two years, and the proportion enrolled in education increased from 1.4 per cent to 17 per cent.

Qualitative data revealed that the main difficulty in finding paid employment was a lack of formal education qualifications, leading many participants to consider returning to education. Because maintaining abstinence was viewed as the most immediate and important goal, a considerable number of participants expressed a preference for employment that was not overly demanding stress-inducing. Some participants reported being unable to secure employment owing to their past criminal activity.

Criminal activity

Qualitative data revealed that most participants had a background involving some level of criminal activity, much of it associated with supporting a lifestyle largely focused on drug acquisition and use. This was particularly the case for male participants. The proportion of participants who reported committing a criminal act in the 30 days preceding data collection fell from 8.6 per cent at baseline to 1.8 per cent at two years.

Conclusions

Despite the many instances of relapse, the authors conclude that the positive impact of all CTC programmes on clients is undeniable. Overall, substance use declined, physical and mental health improved, and clients demonstrated improvements with regard to housing, employment, education and family relationships. Many clients cited the tools they had acquired in treatment as key mechanisms for continued change. Some participants suggested ways in which CTC services could be improved and the authors suggest these 'key messages' could be applicable not only to CTC but to drug and alcohol therapeutic communities more generally:

- flexibility in delivery of programmes, e.g. scheduling, structure, treatment timeline, multiple programming options;
- additional one-to-one support;
- smaller group sessions;
- more support for residential clients moving from residential treatment into community housing with peers;
- day programme as step-down after completing a residential programme; and
- motivation enhancement.

Anne Marie Carew, Brigid Pike and Brian Galvin

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1. Babineau K and Harris A (2016) *Pathways through treatment: a mixed-methods longitudinal outcomes study of Coolmine therapeutic community* Dublin: Coolmine Therapeutic Community. <http://www.drugsandalcohol.ie/25091/>

SPECIAL THEME:
METHADONE MAINTENANCE TREATMENT

Risk factors for death among MMT patients

International studies have shown that problem alcohol or drug users have increased mortality rates in comparison to the general population. Mortality rates are further elevated among individuals with serious opiate addictions, and especially among injecting drug users (IDUs). Methadone maintenance treatment (MMT) is shown to reduce the mortality rate for this cohort of problem drug users, but in comparison to the general population MMT patients still have a higher risk of mortality.

The aim of this study¹ was to explore what risk factors might contribute to increased mortality among MMT patients. The authors stated that they were specifically interested in the hypothesis that methadone dosage and problem use of non-opiate drugs might be associated with an increased risk of mortality. They were also interested in whether there were different risk factors among cases who died from poisoning and cases who died from other causes.

The authors used a matched case-control study. They examined treatment exit records from the National Drug Treatment Centre (NDTC) in Dublin for seven years from February 2005 to February 2012. They identified all patients whose treatment outcome was recorded as death. Cause of death for these cases was determined using information from the National Drug-Related Deaths Index (NDRDI). Controls for the study were MMT patients who had not died, and matching was done by age, gender and treating team.

The authors conducted two separate statistical analyses. Uni-variable associations between risk of death and age, gender, methadone dose, non-attendance at treatment for at least one week prior to death, drug use in the month preceding death, history of imprisonment, HIV status, and medical complications were examined. For the controls, an index date, equal to the date of death, was created, and this was used to analyse the same set of death-related variables. A second analysis was conducted using binary logistic regression with alive/dead as the outcome variable.

Results

Over the seven years of the study the average number of MMT patients at the NDTC was 500, and 80 deaths were recorded over the same period. No statistical difference in methadone dosage was found between cases and controls and neither was there a significant difference in recent use of heroin, benzodiazepines or cocaine. Cases were more likely to have a history of imprisonment ($p<0.001$); not attended the NDTC for at least one week prior to death ($p<0.001$); HIV ($p=0.01$); non-HIV/HCV medical problems ($p<0.001$); and more frequent medical/psychiatric reviews ($p=0.03$).

The logistic regression model reinforced these results with the significant variables found to be history of imprisonment, non-attendance at the NDTC one week prior to death, and a non HIV/HCV medical condition. HIV status was not found to be significantly associated with risk of death using this model.

Poisoning deaths

The authors attempted to delineate between poisoning deaths and other types of deaths, in an attempt to determine if there were different risk factors for deaths in these cases. Poisoning deaths included all drug overdoses (intentional or accidental). Other causes of death included trauma (murder, road traffic accident, etc) and medical causes (infection, organ failure, etc). Cause of death was possible to determine in 77 out of 80 cases; no suicides were recorded, though the authors noted that this might possibly have been under-recorded owing to some coroners recording suicides as 'accident/misadventure'.

Records showed that 33 out of the 80 patients had died of poisoning. The only significant statistical difference between this cohort and cases who did not die of poisoning was a slightly younger average age (34.2 versus 41.3, $p<0.001$). Comparing the poisoning cases with their controls, similar significant associations were found (HIV positive, not attending the NDTC for at least one week prior to death, history of imprisonment, non-HIV/HCV medical problems). The poisoning deaths cohort was also found to have been more likely to have a history of homelessness ($p=0.03$).

Discussion

The authors noted that other studies had shown that increased risk of mortality had been associated with low or very high doses of methadone. No such association was witnessed in this study. Similarly, previous studies had shown an increased risk of mortality among MMT patients with problem cocaine use, but this study showed no significant associations between ongoing problem drug use and risk of mortality.

Three significant associations were identified, however, in relation to imprisonment, medical issues and attendance at the NDTC for MMT.

- Other studies have pointed to the risk of lower tolerance on release from prison being a cause of overdose. The authors of this paper chose to focus on history of imprisonment, and showed that the cases were more likely than the controls to have a history of imprisonment. They theorised that being imprisoned could be linked to prisoners being one of the most disadvantaged groups in society, and noted that previous studies had shown an elevated risk of mortality among ex-prisoners.
- Recent studies have shown that HIV patients who were injecting drug users (IDUs) have a mortality rate 20 times higher than non-IDU patients. This study showed that there were significantly more HIV patients among the case group than the control group. The study also showed a link between non-HIV/HCV medical illness and mortality, as one would expect. Interestingly, among the cases who died of poisoning, medical issues were significantly more common in comparison to controls. The authors suggested that this might be linked to 'increased susceptibility to the respiratory depressant effect of opioids among the medically unwell'. The authors suggested that prevention, and early detection and treatment, may help reduce mortality.

MMT– mortality risk continued

- Other studies have shown an increased risk of mortality among patients who have disengaged from MMT, and especially in the first weeks out of treatment. This study observed that a significant minority of cases had been disengaged from treatment at time of death. The authors recommended educating MMT-patients on the increased risk of overdose if they ceased treatment, and that clinics should follow up on patients, even if they have only been

absent for a short period of time. A pro-active approach, the authors suggested, could help reduce the increased risk of mortality faced by those who disengage.

Martin Grehan

- Truszkowska E, McCarron P, Kononov P, Galander T, Lyons S, Keenan E and Smyth BP (2015) Case-control study of risks and causes of death amongst opioid dependent patients on methadone maintenance treatment. *The Canadian Journal of Addiction* 6 (3): 17–25. <http://www.drugsandalcohol.ie/25004/>

On and off methadone substitution treatment: risks of mortality

A recently published study aimed to assess the risk of death when initiating or stopping methadone treatment in primary care.¹ In addition, the study looked to assess the effect of supervised methadone consumption on mortality rates.

Data from the Central Treatment List (CTL) were used to identify cases that were in receipt of at least one methadone prescription in primary care over the six years between August 2004 and December 2010. The CTL data were linked to the Methadone Treatment Scheme (MTS) dispensing records. These were further linked to the General Medical Services (GMS), which contains information on all other prescription medication, excluding methadone. Finally, these were linked to the mortality data recorded by the National Drug-Related Deaths Index (NDRDI). A case was considered 'off treatment' if the individual had not received a new methadone prescription for three days since the end of their last prescription. They were considered 'off treatment' until a new prescription was generated.

The main outcome measure was drug-related mortality, defined as a death due to poisoning as per the NDRDI definition. The second outcome measure was all-cause mortality.

Table 1: Characteristics of people (alive and dead) receiving methadone treatment, Ireland, August 2004 – December 2010

	Total n=6983	Alive n=6770	Dead n=213
	%	%	%
Male	68.7	65.8	74.2
Age (years)			
16 to 19	7.5	7.7	0.9
20 to 29	50.4	51.0	31.5
30 to 39	31.8	31.6	39.0
40 to 65	10.3	9.7	28.6
Number of treatment episodes			
≤4	46.2	46.0	53.1
≥ 5	53.8	54.0	46.9
Median length of treatment episode (days)	83	85	60
Median dose last treatment episode			
<60mg	38.0	38.2	29.6
60 to 120 mg	59.6	59.3	67.6
≥120 mg	2.5	2.5	2.8
Supervised methadone consumption			
≥50% prescriptions supervised	40.4	40.9	26.8
<50% prescriptions supervised	59.6	59.1	73.2
Co-prescribing	71.2	71.0	78.4
Benzodiazepines	22.8	22.6	28.6
Antipsychotics	48.0	48.0	47.4
Opioid analgesics	39.5	39.4	41.8

Source: Adapted from Cousins et al (2015)

On and off MMT– mortality risk continued

In total, 6,983 cases aged between 16 and 65 years who received methadone were included in the study. Of these, the majority were male (69%) and 57 per cent were aged 29 years or younger (Table 1). The majority of cases had received methadone treatment five or more times, with a treatment period lasting a median of 83 days. Three per cent (n=213) of those included in the study died during the study period.

Of the 213 people who died, 98 (46.0%) were classified as being off methadone treatment. The deaths of over a third (78, 37%) were classified as being due to poisoning. Opiates (n=72) and benzodiazepines (n=56) were the drugs most frequently reported in the toxicology reports on these cases. The risk of dying because of poisoning was highest when a person was off treatment (0.39 deaths per person years) compared to on treatment (0.24 per person years) but this was not statistically significant. For those off treatment, mortality rates from poisoning were highest in weeks one to two (0.49 deaths per person years) and in weeks three

to four (1.19 deaths per person years). Again, there was no statistical difference between the time periods or from those on treatment.

Analysis of all-cause mortality, adjusted for gender, age and comorbidity, showed that people who were off treatment were three times more likely to die than those on treatment (3.6, 95% CI 2.1 to 6.3) (Table 2). The risk of mortality was highest in the third and fourth week after stopping treatment (9.1, 95% CI 3.1 to 26.2). However, the risk of mortality off treatment after five weeks or more remained higher than being on treatment. A higher risk of dying was associated with age and increased co-morbidity, as shown by the median co-morbidity score. The authors noted that in the unadjusted analysis, mortality was higher among those whose methadone consumption was not supervised (1.36, 95% CI 1.00 to 1.84) but this was not found to be statistically significant in the adjusted analysis.

One of the potential limitations of the study was the definition of 'off treatment' as not receiving a methadone prescription for three days since the end of the last prescription. This cut-off was based on UK guidelines which are based on reduction of tolerance. However, a sensitivity

Table 2: All-cause mortality among people receiving methadone treatment, Ireland, August 2004 – December 2010

	Number of Deaths	Mortality/100 person-years	Adjusted analysis Mortality rate ratio (95% CI)	P-value
Overall on treatment	115	0.51	1.00	<0.001
Overall off treatment	98	1.57	3.64 (2.11 to 6.30)	
Period				
Weeks 1 to 2 on treatment	9	0.49	0.88 (0.23 to 3.33)	<0.001
Weeks 3 to 4 on treatment	6	0.39	0.71 (0.14 to 3.51)	
Remainder of time on treatment	100	0.52	1.00	
Weeks 1 to 2 off treatment	29	3.46	6.36 (2.84 to 14.22)	
Weeks 3 to 4 off treatment	15	4.38	9.12 (3.17 to 26.28)	
Remainder of time off treatment	54	1.07	2.46 (1.28 to 4.37)	
Sex				
Female	55	0.59	1.00	0.2
Male	158	0.81	1.54 (0.81 to 2.90)	
Age (years)				
16 to 19	2	0.16	1.00	0.006
20 to 29	67	0.47	3.18 (1.21 to 49.20)	
30 to 39	83	0.83	5.62 (1.36 to 86.82)	
40 to 65	61	1.87	10.40 (4.66 to 164.52)	
Supervised consumption				
Yes	57	0.60	1.00	0.500
No	156	0.81	1.23 (0.67 to 2.27)	
Median comorbidity score*				
0 to 5	130	0.58	1.00	0.007
6 to 10	52	0.95	1.65 (0.87 to 3.13)	
11 to 15	23	2.65	4.66 (1.88 to 11.50)	
> 16	8	5.06	6.06 (1.46 to 25.18)	

Source: Adapted from Cousins et al (2015)

* Measured by number of prescriptions for benzodiazepines, antipsychotics, antidepressants and opiates (excluding methadone) received by participant in a calendar year

On and off MMT–mortality risk continued

analysis extending the cut-off to seven days also showed increased mortality off treatment, (3.06 95% CI 1.74 to 5.39). Another limitation was that people transferring from primary care to specialist methadone clinics were not included and so were classified as 'off treatment'. These limitations were compounded by the lack of information on those who were off treatment, for example they may have been in prison, stopped their opiate use or been hospitalised.

While acknowledging the strengths of the study, such as the large national cohort of people receiving methadone who were included and the detailed prescription data from primary care, the inability to control for the residual confounders noted above is often a problem in such observational studies and the findings from this study should be viewed as a basis for further research. In particular, the authors recommended further research in relation to supervised consumption.

The findings also have implications for national practice and policy as they show that retention in treatment in primary care is associated with a reduced risk of all-cause mortality. The authors also recommended that when a person leaves methadone treatment in primary care there should be improved post-treatment monitoring and follow-up for the first month, when relapse rates are highest along with the greatest risk of dying.

Editorial comment

In response to this newly-published Irish study on the risks of mortality on and off methadone substitution treatment in primary care, Professors Matthew Hickman, John MacLeod and Louisa Degenhardt wrote an editorial in the journal *Addiction*, stating: ²

The National Irish cohort study strengthens evidence on the hazards of leaving opioid substitution treatment (OST) and the dangers of short duration treatment and provides the first piece of evidence for future synthesis of the effect of supervised consumption on mortality risk in people on OST.

In their commentary, they stressed the need for robust and reliable evidence to enable service providers to provide the best possible drug treatment in order to reduce mortality in this vulnerable cohort of people. This evidence is particularly pertinent when wanting to understand if changes in drug treatment have had any impact on mortality or outcomes. The professors also noted that this Irish study had provided some weak evidence suggesting that supervised consumption may reduce the risk of mortality but further evidence is needed to build on this finding.

Suzi Lyons

1. Cousins G, Boland F, Courtney B, Barry J, Lyons S and Fahey T (2015) Risk of mortality on and off methadone substitution treatment in primary care: a national cohort study. *Addiction* 111 (1): 73–82. <http://www.drugsandalcohol.ie/24374/>
2. Hickman M, Macleod J and Degenhardt L (2016) Commentary on Cousins et al (2016): Accumulating evidence on risk of mortality on and off opioid substitution treatment. *Addiction* (111): 83–84.

POLICY AND LEGISLATION

Next National Drugs Strategy under development

The Cabinet Committee on Social Policy and Public Service Reform has mandated the Department of Health to develop a new National Drugs Strategy, to follow the current National Drugs Strategy which will expire at the end of 2016.¹ Late in 2015 the Minister with responsibility for the National Drugs Strategy established a Steering Committee to provide him with guidance and advice in the development of the new Strategy. This Committee met for the first time on 8 December 2015.

Steering committee

The Steering Committee is tasked with considering how the new Strategy should address problem drug use, including the structures through which this could be done, and developing

performance indicators to measure the effectiveness of the new Strategy. It will present a draft report to the Oversight Forum on Drugs for discussion and amendment, and then submission to the Minister with responsibility for the National Drugs Strategy, who will submit the proposed new Strategy to the Cabinet Committee on Social Policy and Public Service Reform for approval. The new Strategy is expected to be finalised by the end of 2016.

The Steering Committee has a comprehensive and wide ranging membership, representing the key government departments and agencies responsible for implementing the Strategy as well as the community and voluntary sectors and the drugs and alcohol task forces. John Carr, a former general secretary of the Irish National Teachers Organisation, is the independent chair of the Steering Committee. The work of the Steering Committee will be informed by the following inputs, delivered over the first half of 2016 – a report from an international expert review group, an evidence briefing compiled by an independent academic institution, and feedback from focus groups.

International expert review group

During a week-long visit to Ireland in January 2016, a group of three international experts undertook a high-level review of the current National Drugs Strategy, and reported to the Steering Group on their findings and observations.

Next National Drugs Strategy

continued

This expert review group included Paul Griffiths, Scientific Director with the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), who will chair the group; Nicola Singleton, also of the EMCDDA; and Professor John Strang of the National Addictions Centre, Kings College, London. The group's terms of reference included examining the progress and impact of the current National Drugs Strategy in the context of the objectives, key performance indicators and actions set out in the Strategy; identifying deficits in the implementation of the Strategy; summarising success factors or barriers to success; commenting on Ireland's evolution in tackling the drug problem in the light of international trends; and identifying key learning points arising from the Strategy and highlighting areas to consider for development in the new strategy.

Independent evidence briefing

During the first four months 2016 a two-part evidence briefing, compiled by researchers at Liverpool John Moores University, was presented to the Steering Committee. It comprises (1) a report on the drugs situation in Ireland, including a ten-year trend analysis, and (2) an overview of international evidence on interventions in the following response areas – prevention (universal, selective and indicated), harm reduction, treatment (medical, psychosocial and residential modalities, and social reintegration (rehabilitation and recovery).

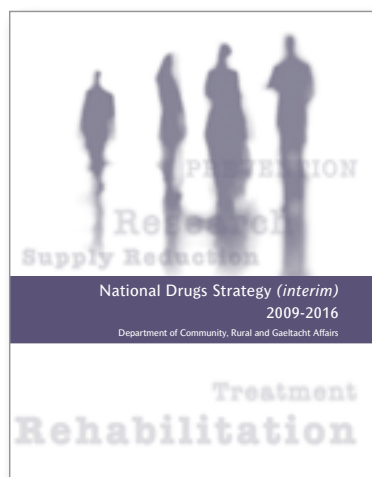
Focus groups

To enable engagement with statutory, community and voluntary bodies who have a role in the delivery of the objectives of the Strategy, the Steering Committee will establish four focus groups to consider the following topics:

- Supply reduction
- Education and prevention
- Continuum of care (encompassing treatment, rehabilitation and recovery)
- Evidence and best practice

Chaired by the Chair of the Steering Committee, these focus groups will meet in the first months of 2016 and give their views on the relevance of the current Strategy in tackling problem drug use in Ireland, identify any gaps presenting and indicate how they believe these gaps might be addressed.

It is envisaged that the new Strategy will take account of national policy frameworks such as the National Action Plan for Social Inclusion 2007–2016² and the Healthy Ireland Framework³ as well as international policies, such as the EU Drugs Strategy 2013–2020⁴ and the associated Action Plan,⁵ which is supported by Ireland.



The Cabinet Committee has stipulated that there should be a fundamental review of all aspects of the current National Drugs Strategy, including the role of the drugs and alcohol task forces. Issues that the Steering Committee has been particularly asked to consider are:

- the length of the Strategy, and whether to develop a more concise and focused version, to facilitate clear and concise reporting on progress and implementation;
- the optimum duration of the Strategy in order to reflect the changing nature of the drugs phenomenon and the need to maintain the momentum necessary to keep pace with changing drug trends;
- the five pillars and whether new or alternative pillars are needed to ensure that the Strategy is focused on new or emerging issues; and
- the appropriate balance between the objectives of supply reduction and demand reduction.

This report is based on information provided by the Drug Policy Unit in the Department of Health in December 2015.

1. Department of Community, Rural and Gaeltacht Affairs (2009) *National Drugs Strategy (interim) 2009–2016*. Dublin: Department of Community, Rural and Gaeltacht Affairs. <http://www.drugsandalcohol.ie/12388/>
2. Office for Social Inclusion (2007) *National action plan for social inclusion 2007–2016*. Dublin: Stationery Office. <http://www.drugsandalcohol.ie/13378/>
3. Department of Health (2013) *Healthy Ireland – a framework for improved health and wellbeing 2013–2025*. Dublin: Department of Health. <http://www.drugsandalcohol.ie/19628/>
4. Council of the European Union (2012) *The EU drugs strategy 2013–2020*. Brussels: Council of the European Union. <http://www.drugsandalcohol.ie/19034/>
5. Council of the European Union (2013) *EU action plan on drugs (2013–2016)*. Brussels: Council of the European Union. <http://www.drugsandalcohol.ie/20004/>

What's in a drugs strategy?

While work is proceeding on developing the strategic approach that will be adopted when the current National Drugs Strategy 2009–2016 expires at the end of this year, *Drugnet Ireland* takes a look at a selection of current drugs strategies from around the world to explore the range of approaches that are being taken to this complex and hydra-headed challenge.¹

Coverage

Many countries have extended the range of their strategies beyond illicit substances to include licit substances.

Australia	Alcohol, tobacco, cannabis, methamphetamines and other stimulants, new psychoactive substances, opioids, and misused pharmaceuticals
Cyprus	Drugs and harmful use of alcohol
New Zealand	Alcohol and other drugs
Norway	Alcohol, illicit drugs, addictive medications and doping
Spain	Addictive substances, whether they be those that are legally traded, such as alcohol, tobacco and certain pharmaceutical drugs, or those excluded from legality
Sweden	Alcohol, narcotic drugs, doping and tobacco
United Kingdom	Illicit drugs and alcohol dependence
United States	Controlled drugs including prescription drugs, alcohol and tobacco

Four countries in the EU have extended their strategic reach further, to include addictive behaviours as well as substances.

Czech Republic	Illicit drugs, alcohol and gambling
Croatia	Illicit drugs, precursors and new psychoactive substances and doping, licit drugs (alcohol, tobacco, prescription medications), and other addictions (gambling, the Internet)
France	Illicit drug use, alcohol, tobacco, psychotropic medications and other addictive behaviours such as doping, gambling and gaming
Germany	Addictive substances and behaviours, including alcohol, tobacco, prescription drug addiction and prescription drug abuse, pathological gambling, online media addiction and illegal drugs.

Aspirations and goals

Traditionally, 'balanced' drugs strategies have been built around the twin aspirations of reducing supply and demand, with actions grouped under themes such as enforcement, prevention, treatment and rehabilitation. The UK Drug Policy Commission, an independent charity that sought to provide objective analysis of the evidence concerning drug policies and practice, suggested that attention should shift at the strategic level from focusing on 'inputs' to looking at the desired outcomes:

We suggest making a clear distinction between the overall goals of drug policy and the tools to deliver it. Rather than starting with the traditional distinction between prevention, treatment and enforcement, it may be more effective to consider drug policy in terms of two higher level challenges (p. 11).²

These two higher-level challenges were characterised as follows:

1. How can society and government enable and support individuals to behave responsibly, i.e. tackle the underlying causes of drug use, providing the information and skills to make sensible choices, and, where drug use does occur, minimise the associated harms?
2. How can society and government enable and promote recovery from entrenched drug problems, be it individuals or communities?

Another way of shifting the focus on to outcomes has been tried by New Zealand and Scotland, who have set their national drugs strategies within the framework of broader, over-arching public sector outcomes. In New Zealand, the thinking is that progress towards the twin drug policy goals of minimising harm and promoting and protecting the health and well-being of all New Zealanders will impact on four wider social sector outcomes:

- reducing welfare dependency,
- supporting vulnerable children,
- boosting skills and employment, and
- reducing crime.¹

The current Scottish drug strategy, launched in 2008, is similarly located within the context of the Scottish government's 'overarching purpose, which is to increase sustainable growth'.³ This purpose is supported by a National Performance Framework, which cascades down through five strategic objectives (to make Scotland wealthier & fairer, smarter, healthier, safer & stronger, and greener) and 15 national outcomes to 45 national indicators. One of the 45 indicators is to 'reduce the estimated number of problem drug users in Scotland by 2011'. The Minister wrote in his Foreword to the drug strategy, 'Reducing problem drug use will get more people back to work; revitalise some of our most deprived communities; and allow significant public investment to be redirected'(p. iv).

What's in a drugs strategy? continued

Principles and values

National drug strategies that adopt a balanced, integrated approach, focusing on reducing both supply and demand (e.g. Croatia, Czech Republic, France, Germany, Slovakia, Slovenia and Spain), tend to include instrumental guiding principles, as does the Australian drugs strategy, which takes a harm-minimisation approach. These instrumental guiding principles include:

- long-term and comprehensive planning,
- realistic decision making – using evidence and evaluation of effectiveness,
- rational funding and service quality guarantee,
- partnership and common approach,
- professional cooperation at system interfaces and networks,
- reaching people in a local context,
- taking the most vulnerable, high-risk population groups into account in order to reduce health and social risks and negative impact, including a focus on gender sensibilities, and
- social participation as a way of raising awareness in society at large.

'European values', i.e. 'human dignity, freedom, equality and solidarity ... democracy and the rule of law',⁴ are explicitly mentioned in the drugs strategies of several Eastern European countries (Croatia, Czech Republic, Slovakia and Slovenia). The Croatian and Slovenian drugs strategies also list human rights protection among their guiding principles.

Compassion is highlighted in two national drugs strategies. In New Zealand, compassion is identified together with innovation and proportionality as an essential ingredient if alcohol and other drug problems are to be truly recognised as health issues. In his introduction to the 2015 US National Drug Control Strategy, President Obama wrote that his administration was pursuing a drug policy that is 'effective, compassionate and just'. He went on to write about erasing the stigma of addiction, ensuring both treatment and a path to recovery, and reforming the criminal justice system to provide alternatives to incarceration for non-violent, substance-involved offenders and improving re-entry programmes.

The need to focus on the individual and their families is highlighted in two national drugs strategies that have adopted a strong value-driven ambition to eradicate drug use from society:

- Sweden: The strategy's overall objective – a society free from illegal drugs and doping, with reduced alcohol-related medical and social harm, and reduced tobacco use – is based on a vision of a society where all may grow up, live and work without risking harm through their own use of alcohol, narcotic drugs, doping substances or tobacco, or through such use by others. As well as

the principles of shared responsibility, a long-term perspective and increased coordination and cooperation, the strategy calls for 'a comprehensive, integrated approach focused on the individual/user and the family'.

- United Kingdom: The current strategy shifts the focus from harm reduction to recovery. Holistic solutions are to be centred around each individual, with the expectation that full recovery is possible and desirable. The option of decriminalisation is rejected as failing to have regard to the harms that drugs pose to the individual: 'It neither addresses the risk factors which lead individuals to misuse drugs or alcohol, nor the misery, cost and lost opportunities that dependence causes individuals, their families and the wider community (p. 2).'

Brigid Pike

1. Commentary and documents relating to EU member states with current national drugs strategies, and also Norway and Turkey, were retrieved from the web site of the European Monitoring Centre for Drugs and Drug Addiction <http://www.emcdda.europa.eu/countries>. Only strategies written in or translated into English, and current in 2016, have been considered. Information on the national drugs strategies of selected non-EU countries were retrieved from the following web sites: Australia: <http://www.nationaldrugstrategy.gov.au/>; New Zealand: <http://www.health.govt.nz/publication/national-drug-policy-2015-2020>; United States: <https://www.whitehouse.gov/ondcp/national-drug-control-strategy>
2. UK Drug Policy Commission (2012) *A fresh approach to drugs: the final report of the UKDPC*. London: UKDPC. <http://www.ukdpc.org.uk/wp-content/uploads/a-fresh-approach-to-drugs-the-final-report-of-the-uk-drug-policy-commission.pdf>
3. Scottish Government (2008) *The road to recovery: a new approach to tackling Scotland's drug problem* Edinburgh: The Scottish Government. <http://www.gov.scot/Publications/2008/05/22161610/0>
4. Preamble to the European Charter of Fundamental Rights, http://ec.europa.eu/justice/fundamental-rights/charter/index_en.htm

Help not Harm symposium

On 28 January 2016 Help not Harm held a pre-election symposium in Dublin with contributors speaking on three themes – failures of the criminal justice approach and of government efforts, and exploring what works?¹

Failures of the criminal approach

Catherine Comiskey, Head of School of Nursing and Midwifery, TCD, outlined how the growing body of research-based evidence shows that drug treatment 'works' and strengthens the case for a stronger focus on respecting the human rights of drug users.

Peter McVerry, Executive Director of the Peter McVerry Trust,² argued that, given that the 'war on drugs' has not worked and given that it has proved impossible to reduce the supply of drugs, it is important to focus on seeking to reduce demand. He called for greater investment in treatment options – to eliminate waiting lists and to expand residential and after-care service provision. He argued that this additional investment could be cost-neutral if decriminalisation were adopted as a policy at the same time: the savings in the criminal justice system could be channelled into drug treatment.

Mark Kelly, Executive Director of the Irish Council of Civil Liberties (ICCL), spoke about the submission that ICCL had made to the Joint Committee on Justice, Defence and Equality on the review of Ireland's approach to the possession of limited quantities of certain drugs in August 2015.³ In it the ICCL stated:

Human-rights-sensitive drug policy should be evidence- or science-based. While the state has a recognised, albeit variable, margin of appreciation, human-rights-based policy should not be ideology- or prejudice-driven, nor should it be judgmental. There is a strong case for redesigning drug policies if it is true that they are not achieving their objectives and, instead, have significant unwanted, undesirable or even unacceptable effects, all the more if they impinge on the enjoyment of human rights.

Kelly went on to discuss five articles in the European Convention on Human Rights (ECHR) and how drug policies can contravene each of them:

- Right to life (Art 2 ECHR)
- Prohibition of torture and inhuman or degrading treatment or punishment (Art 3 ECHR)
- Prohibition of forced labour/slavery (Art 4 ECHR)
- Right to liberty and personal freedom (Art 5 ECHR)
- Prohibition of discrimination (Art 14 ECHR)

Damon Barrett, Director of the International Centre on Human Rights and Drug Policy,⁴ took the argument further, arguing that drug prohibition *per se* is contrary to human rights, in other words, from a human rights perspective the use of criminal law to achieve a social goal is inappropriate.

Government efforts

Cormac O'Keefe of the *Irish Examiner* interviewed two TDs – Jonathan O'Brien of Sinn Féin and Aodhán Ó Riordáin of the Labour Party. Both politicians spoke in favour of decriminalisation. They pointed out that various harm reduction measures, such as medically-supervised injecting centres and pill testing, entail some degree of decriminalised drug use.

What works?

Josie Smith, Head of Substance Misuse at Public Health Wales,⁵ described two public health programmes operating in Wales:

- WEDINOS – a national framework for the collection, analysis and dissemination of information relating to novel and/or unknown substances and combinations of substances, both psychoactive and performance/image enhancing drugs, to improve the provision of relevant harm reduction advice and service development.
- Harm Reduction Database Wales – a national web-based surveillance system to evidence effective interventions including needle and syringe programmes, take-home Naloxone, fatal and non-fatal drug poisoning reviews and sexual health.

Aisling Reidy, Senior Legal Advisor with Human Rights Watch,⁶ described the work of Human Rights Watch based in New York. She noted that a range of UN bodies such as UNAIDS have called for a harm reduction approach to be adopted by the UN drug policy agencies.

Denis O'Driscoll, Chief II Pharmacist in HSE Addiction Services, spoke about the Naloxone Project which was launched in Ireland in May 2015.

Concluding discussion

In the concluding discussion, several themes were highlighted:

- Saving lives and reducing the harms of drugs are the priority.
- Drug policy needs to get out of the way of good social policy.
- A human rights approach to drug policy needs an evidence base.

Brigid Pike

1. For more information, visit <http://www.helpnotharm.org/>

2. For more information, visit <https://www.pmvtrust.ie/>

3. Retrieved 1 February 2016 <http://www.iccl.ie/iccl-submission-to-the-oireachtas-joint-committee-on-justice-defence--equality-on-the-review-of-irelands-approach-to-possession-of-limited-quantities-of-certain-drugs.html>

4. For more information, visit <http://www.hr-dp.org/>

5. For more information, visit <http://www.wales.nhs.uk/sitesplus/888/page/72997>

6. For more information, visit <https://www.hrw.org/>

Terminology and information on drugs

The most recent revision of the UNODC's *Terminology and information on drugs*¹ presents introductory information on the better known psychoactive substances under international control. This includes both the scientific names of these substances and the names by which they are commonly known. The revision follows changes in the manufacturing and marketing of drugs and recent scheduling decisions by the Commission on Narcotic Drugs.

The publication is a basic guide to patterns of abuse of these drugs, their effects and potential medical use. It also provides a useful explanation of the schedules in the international drug control treaties. These were established to allow control of certain substances while ensuring their continued availability for legitimate medical and scientific purposes.

The types of substances on which information is provided are cannabis; synthetic cannabinoid receptor agonists; opium and opiates; opioids; coca and cocaine; amphetamine-type stimulants; central nervous system depressants; and hallucinogens.



A glossary provides definitions of terms in common use to describe the preparation, use, effects and consequences, as well as common legal terms relating to the marketing of illicit drugs and official efforts to counter this.

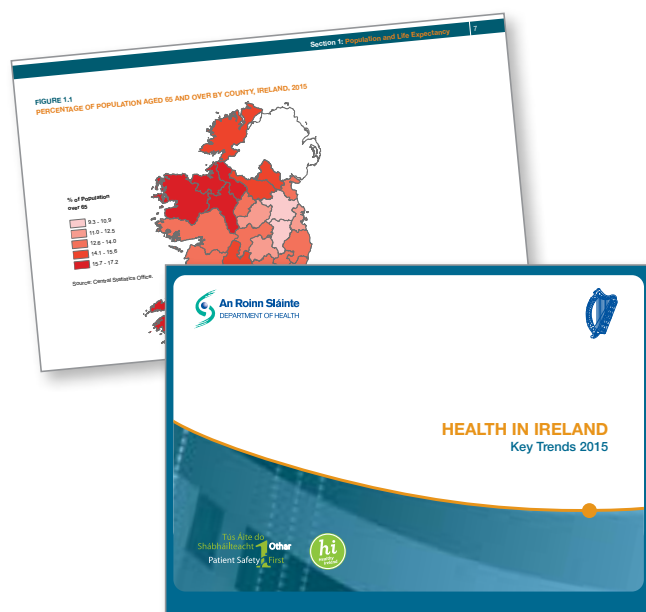
1. United Nations Office for Drug Control and Crime Prevention (2016) *Terminology and information on drugs*. Third edition. New York: United Nations. <http://www.drugsandalcohol.ie/5792/>

PREVALENCE AND CURRENT SITUATION

Health in Ireland: key trends 2015

Published by the Department of Health, this booklet provides summary statistics on health and health care in Ireland over the past 10 years.¹ The data are organised in six chapters ranging from population, life expectancy and health status to health care delivery, staffing and costs. In the Introduction, the authors comment:

In the area of health determinants, lifestyle factors such as smoking, drinking, levels of physical activity and obesity continue to be issues which have the potential to jeopardise many of the health gains achieved in recent years. Furthermore, inequalities in health are closely linked with wider social determinants including living and working conditions, issues of service access, and cultural and physical environments. Taken together with an ageing population, adverse trends, if not addressed now, will lead to an unhealthy and costly future.



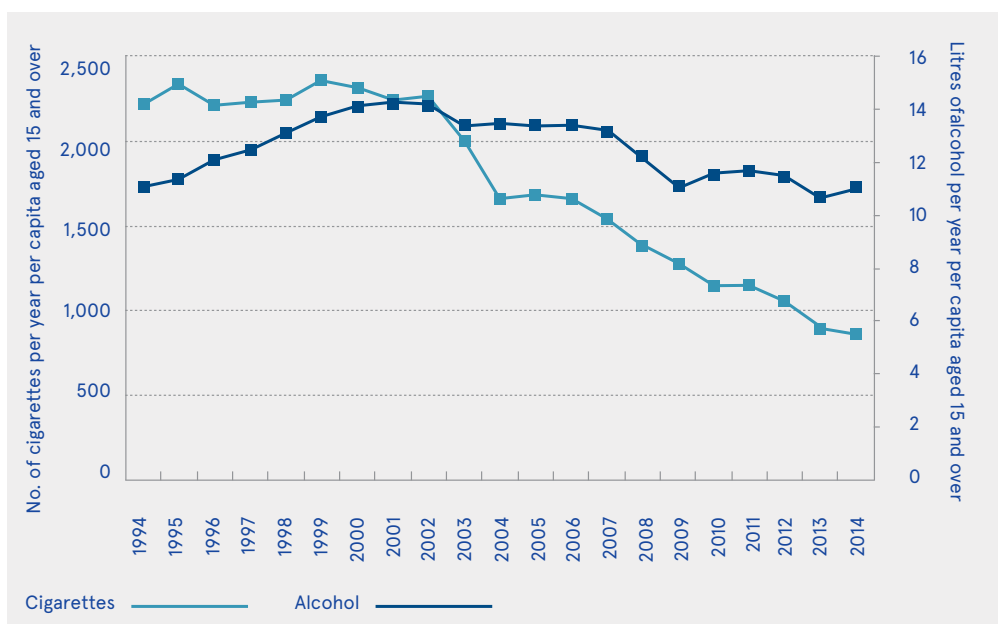
Health in Ireland continued

Alcohol and smoking

Figure 1 shows overall trends in alcohol and cigarette consumption over the last 20 years. Having levelled off over the last few years, the data for alcohol show an increase in consumption in 2014, following a drop in 2013. With respect to cigarettes, the declining figures based on excise duty data need to be treated with caution owing to the effects of cross-border and illegal sales.

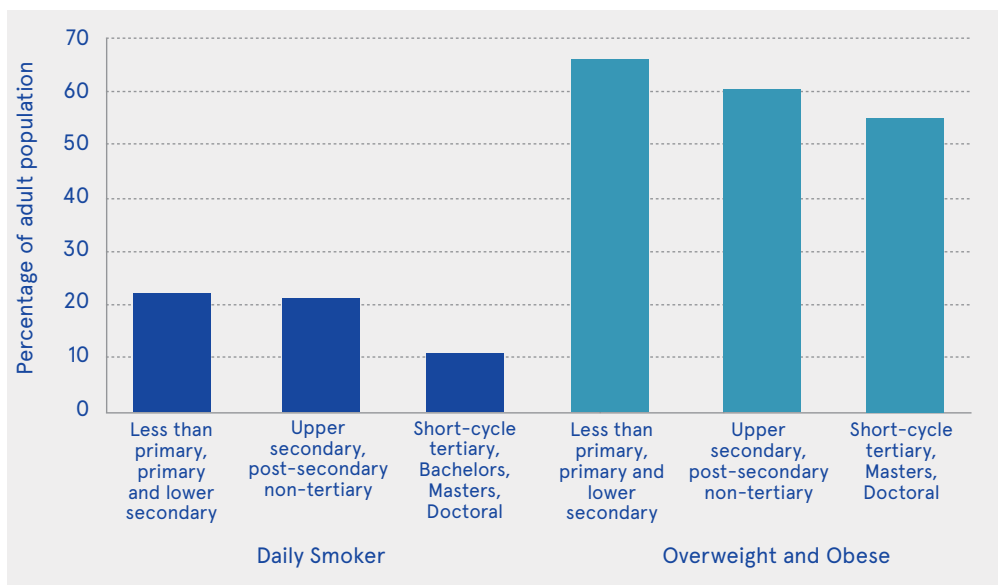
Figure 2 shows the percentage of adults who are daily smokers or are overweight and obese by their educational attainment. In both cases, the rates of daily smoking and persons classified as overweight and obese are lower among those who attained a tertiary-level qualification.

Figure 1: Alcohol and cigarette consumption per annum among population aged 15 years and over, 1994–2014



Source: *Health in Ireland* (2015) Figure 2.10, based on data from Revenue Commissioners and CSO
 Note: Alcohol is measured in terms of pure alcohol consumed, based on sales of beer, cider, wine and spirits.
 Tobacco is measured in terms of sales of cigarettes recorded by the Revenue Commissioners.

Figure 2: Daily smokers and persons classified as overweight or obese, by educational attainment, 2015



Source: *Health in Ireland* (2015) Figure 2.11, based on data in the Healthy Ireland Survey 2015

Health in Ireland continued

The number of people who drink more than six standard units of alcohol at least once a month, broken down by gender and social class, can be seen in Figure 3. It shows that men and those in the lower social group are more likely to engage in risky single-occasion drinking at least once per month.

The results of the Irish Health Behaviour in School-aged Children (HBSC) survey 2014, when compared to the HBSC survey of four years earlier, show that the proportion of Irish children aged 10–17 years who are current smokers or who

Figure 3: Risky single-occasion drinking (6 or more standard units) at least once per month in the previous 12 months, by gender and socio-economic classification, 2015

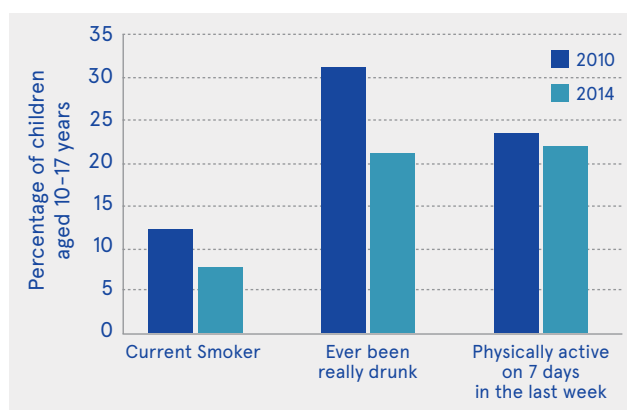


Source: *Health in Ireland* (2015) Figure 2.12, based on data in the Healthy Ireland Survey 2015

Notes: (1) Risky single-occasion drinking is defined as six or more standard drinks. (2) Sample refers to those who regularly drink alcohol (n=5,694) according to the Healthy Ireland survey and excludes those who never drink alcohol/abstain (n=1,845)

have ever been really drunk have both declined over the four year period (Figure 4). A review of the trend in the level of lifetime drunkenness among Irish school-aged children between 1998 and 2014 shows that it decreased over the 20-year period and most markedly among 13–15-year-olds.² This overall trend is welcome, especially among younger teenagers, as the immaturity of their brains makes them particularly vulnerable to the harmful effects of alcohol. Delaying initiation of drinking also decreases the likelihood of developing alcohol dependence in later life.

Figure 4: Child health behaviours in smoking, alcohol and physical activity in Ireland, 2010 and 2014



Source: *Health in Ireland* (2015) Figure 2.13, based on Health Behaviour in School-Aged Children (2014)

Table 1: Number of cases in treatment for problem drug use and rate per 100,000 aged 15–64 years, 2005–2014

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	% Change	
											2005–2014	2013–2014
All cases in treatment*	12,101	12,737	13,597	14,518	14,933	16,429	16,329	16,286	17,375	18,342	51.6	5.6
New entries into treatment each year†	2,054	2,278	2,476	2,716	2,970	3,270	2,978	3,008	3,205	3,491	70.0	8.9
per 100,000 15–64 year olds	72.8	78.3	82.0	88.0	95.9	106.1	97.1	98.9	106.2	116.1	59.5	9.3

Sources: *Healthy Ireland* (2015) Figure 4.6

* Central Treatment List (n=9,296) and National Drug Treatment Reporting System (NDTRS) (n= 9,046)

†NDTRS only

Notes: (1) Each record in the NDTRS database relates to a treatment episode (a case) and not to a person. This means that the same person could be counted more than once in the same calendar year if he/she had more than one treatment episode in that year. Additionally, the same case may appear in both the CTL data and the NDTRS data as there is no unique identifier yet in Ireland. (2) Both the CTL and the NDTRS data exclude those treated in prison. (3) NDTRS data for 2014 is preliminary. (4) NDTRS does not include cases treated for alcohol as a main problem drug.

Treatment for problem drug use

Between 2005 and 2014 the number of cases treated for problem drug use in Ireland increased almost 52 per cent (Table 1). The number of new entrants into treatment also increased, but by a larger proportion (70%). The authors of the most recent bulletin on NDTRS and CTL data on treated problem drug use,³ which revealed a similar 52 per cent increase between 2005 and 2010, commented that the 'clear spread and increase in treated drug use throughout the country' reflected 'not only the extent of problem drug use but also an increase in treatment availability and compliance with the NDTRS', an observation which is still pertinent today.

Brigid Pike

1. Department of Health (2015) *Health in Ireland: key trends 2015*. Dublin: Department of Health. <http://www.drugsandalcohol.ie/24955/>
2. Mongan D (2016) Health behaviour in school-aged children *Drugnet Ireland* (56) 14–16. <http://www.drugsandalcohol.ie/25144/>
3. Bellerose D, Carew AM and Lyons S (2011) *Trends in treated problem drug use in Ireland 2005–2010*. HRB Trends Series 12. Dublin: Health Research Board. <http://www.drugsandalcohol.ie/16381/>

Misuse and dependence on codeine-containing medicines

Concerns have been growing globally regarding the misuse of both prescribed and over-the-counter (OTC) codeine, with research showing that both demand for codeine and misuse of OTC codeine have increased. In 2010 the Irish Pharmacy Regulator published guidance for pharmacists on the safe supply of non-prescription codeine-in-combination products to patients.¹ This guidance was published following the enactment of the Pharmacy Act 2007² and the Regulation of Retail Pharmacy Businesses Regulations 2008.³ The guidance states that these products are to be supplied only as 'second-line' medicine for pain-relief treatment. Detailed advice is also to be provided to patients about the correct short-term use of the products.

'Codeine is my companion'

Following the above changes, a study was undertaken in Ireland to obtain individual and collective experiences of codeine use, and to gain an understanding of the pathways to misuse and dependence and of people's experiences of treatment services.⁴ It was a qualitative study, based on in-depth interviews with 21 adult codeine 'misusers' (either currently using, in treatment or recovery) who were accessing, or had accessed, treatment services, and with their dependants.

To date, there have been only a few Irish studies on problem codeine users. These have shown that users tend to be male, with a history of psychiatric problems, co-existing medical problems and/or poly-drug use. Quantifying the extent of misuse or dependence on codeine-containing medicines in Ireland has been difficult. The authors of the research study cite data from the National Drug Treatment Reporting System (NDTRS) for the period 2008–2012, which show that 1.9 per cent of people in drug treatment in Ireland had reported codeine as their primary or secondary problem drug.

Severity of dependence

Interviewees all completed the severity of dependence screener (SDS).⁵ Just over half of interviewees were women (12, 57%); their ages ranged between 26 and 62 years, with 71 per cent being aged between 30 and 49; and 52 per cent were unemployed. With regard to substance use, the interviewees reported as follows:

- 15 (71%) had used codeine within the last 12 months. Of these, 12 (80%) scored 10 points or higher in the SDS.
- 18 (86%) used codeine as their primary problem drug. Of these, two (11%) reported using other opiate-type drugs, and 13 (62%) reported using codeine in combination with ibuprofen (e.g. Nurofen plus) as their primary drug of use. This combination was described by many of the interviewees as 'optimal for intoxication purposes' as opposed to other combinations, particularly with caffeine, which caused unwanted side effects such as nausea.

- 14 (67%) were currently on methadone maintenance treatment.
- 3 (14%) were on Suboxone treatment.
- Several had a history of use of other illicit drugs.

Themes emerging from interviews

Two higher-level concepts emerged from the analysis of the interviews – (1) emotional pain and user self-legitimation of use, and (2) entrapment into habit-forming and invisible dependent use. In addition, the authors identified 10 themes with 82 categories. Some of the themes are highlighted below.

Awareness of habit-forming use and harm

Most interviewees reported that they were not aware that codeine was addictive or of the potential harms of ibuprofen and paracetamol. While only two said they had read the product information leaflet, most felt prescribing doctors should provide more information about use and the associated risks. Almost all had accessed the internet to learn which products contained codeine.

Negotiating pharmacy sales

All reported accessing codeine mainly from pharmacies. This often involved going to many different pharmacies in different locations and at different times in order to avoid suspicion. All were aware of the restrictions on the sale of codeine products and adapted to circumvent these measures. If an interviewee had been recognised by staff, they reported evasion tactics such as purchasing other products. However, interventions from pharmacists did sometimes lead participants to think about misuse.

Alternative sourcing routes

Interviewees reported asking family members or friends to purchase codeine products or obtain prescriptions on their behalf, crossing the border or travelling to areas with less strict rules around codeine products, 'doctor shopping' with stories of pain, and forging prescriptions. Two interviewees who were healthcare professionals reported stealing from work.

The codeine feeling

Most interviewees started to use codeine for legitimate pain-related reasons. However, many described how they progressed within several weeks to taking the drug for its pleasurable effects or for emotional reasons rather than to alleviate physical pain.

I had really no treatment [for depression] but I was totally dependent on the codeine, codeine was my treatment, codeine was my life.

The daily routine and acute and chronic side-effects

Interviewees reported that misuse started within weeks, often involving intense cravings and the need to take codeine 'to feel normal' and to get through the day. Maximum daily consumption ranged from 24 to 115 tablets. Although many did not exceed the recommended dose, they misused the products over a long period. Several commented on the cost and time spent supporting their misuse. Reported side-effects included distorted vision, itching, constipation, rebound headaches, nausea, loss of appetite and of weight.

Codeine-containing medicine continued

Social isolation

Social isolation and the damaging effect of addiction on family relationships were noted by some interviewees. The preoccupying nature of the dependence on codeine was cited as a reason for isolation from family and friends.

I don't really have any friends any more. My friends are gone and it's more a companion addiction. It feels like it has its arm around you. That's how it is for me now. It gives me that sense of security and that's what I am struggling with at the moment, it's to break that cycle.

Withdrawal and dependence

The side-effects of withdrawal were one of the reasons several interviewees reported for continuing misuse, trying to self-regulate the amounts taken to keep up normality. Many had unsuccessfully tried to self-detox.

I tried to cut down on it, gradually cut down, and then I'd just have a bad day and I'd be straight back up to 24 [tablets].

Help-seeking and treatment experiences

There was an overall positive feeling towards treatment services and pharmacists when seeking help. The barriers to treatment revolved largely around the stigma associated with addiction and being labelled a drug addict. All the interviewees who commenced on tapered doses of codeine phosphate relapsed, reporting it did nothing to alleviate their cravings. Suboxone, however, was viewed very positively by the two individuals who took the drug, removing both cravings and withdrawal symptoms.

It was a miracle, a door opened for me, I was able to function, I was on no codeine. I actually walked into the chemist and I apologised to everyone who I had fooled.

Some interviewees indicated a preference for more involvement by pharmacists, rather than mainstream drug treatment facilities, in assisting treatment of addiction.

Conclusions

This qualitative study gives an additional perspective on codeine misuse and dependence addiction in Ireland, highlighting the roles of habit-forming use (encouraged by covert behaviours) and of self-medication for the relief of emotional distress in addiction formation. Given the availability of codeine-containing products and the lack of uniformity in diagnosing what is misuse of opioid pharmaceuticals, interventions for referral, treatment and management of codeine misuse remain limited.

The authors highlight the need to improve treatment pathways, and the availability and management of treatment for this group. They also highlight the need to proactively tackle the availability of codeine-containing medicines, minimise the risks associated with use when required for pain relief, and enhance consumer awareness. These initiatives need to be driven by both public health and regulatory bodies.

Derek O'Neill

1. Pharmaceutical Society of Ireland (2010) *Non-prescription medicinal products containing codeine: guidance for pharmacists on safe supply to patients*. Retrieved 1 April 2016 at http://www.thepsi.ie/Libraries/Consultations/Final_Codeine_Guidelines.sflb.ashx
2. Pharmacy Act 2007 (Private Act No. 20 of 2007). Retrieved 1 April 2016 at <http://www.irishstatutebook.ie/eli/2007/act/20/enacted/en/html>
3. Regulation of Retail Pharmacy Businesses Regulations, 2008 (S.I. No. 488 of 2008) Retrieved 1 April 2016 at <http://www.irishstatutebook.ie/eli/2008/si/488/made/en/print>
4. Van Hout MC, Horan A, Santlall K, Rich E and Bergin M (2015) 'Codeine is my companion': Misuse and dependence on codeine containing medicines in Ireland *Irish Journal of Psychological Medicine*, Early online, pp. 1–14. <http://www.drugsandalcohol.ie/24912/>
5. Severity of Dependence Screener is a five-item questionnaire used to determine dependence in the past 12 months in order to determine dependent and non-dependent use.

The internet and drug markets

Probably the most profound change in the market for illicit drugs over the past twenty years has been the proliferation of synthetic psychoactive substances, sometimes designed to mimic the effect of traditional plant-based drugs. Alongside this emergence of a vast range of new drugs, the mechanisms by which users obtain drugs are also being rapidly transformed. While the deal on the street corner or supply by a friend still dominate exchange in illicit drug markets, online purchasing is becoming a more common form of transaction.

A recent collection of studies published by the EMCDDA points out that almost any kind of drug can be purchased on line and delivered through the postal system without any direct contact between buyer and provider.¹ Given the nature of the illicit drug market, offline encounters bring with them considerable risk of physical harm or arrest. The anonymity provided by the internet offers a degree of safety to both buyer and seller who can operate from whatever location they choose. It also offers the potential for markets to expand rapidly, still operating in a covert manner.

As our economic and social lives move increasingly online, the threats to privacy and personal security from those who wish to use our information is a constant theme in public discourse around internet usage. Countering such threats is a significant driver of new internet technology and innovation in this area is expertly exploited to keep criminal activity hidden. This collection of papers examines several aspects

The internet and drug markets continued

of the role of the internet in drug markets and is a very useful overview of this topic and builds on a growing body of work in this area in recent years.^{2,3}

The surface web

The extent to which online communication is, or can be, hidden defines the various levels at which business is conducted on the internet. Online pharmacies and other sources of non-controlled substances use the accessible surface web. This is also the level at which new psychoactive substances (NPS) can be exchanged between countries with differing levels of control and where discussion around new drugs takes place on social media. NPS are often sold on the surface web as 'research chemicals'. While sales of NPS in dark net markets are increasing, the surface web, where most online shops and pharmacies are based, is the most common source of new drugs.

The dark net

Below the surface web, in parts of the internet not accessible to standard web browsers, is where the dark net markets or cryptomarkets operate. This part of the web is only accessible using special software such as The Onion Router (TOR), which facilitates online anonymity and makes the type of clandestine exchanges used in the supply of illicit drugs possible, and bitcoin, a special trading currency for online transactions. Projects monitoring the dark net report that around 70 per cent of all drug-related sales on cryptomarkets are for cannabis, ecstasy and cocaine-related products.

Separate chapters in the EMCDDA collection of studies explain the technology behind the specialised browsing software and encryption and cryptocurrencies and how they have been used to hide the identity of both vendors and buyers in black market goods.

The Silk Road

The Silk Road, established in 2011, is probably the best known drug-related cryptomarket. Apart from the guarantee of anonymity this website functioned in many respects like mainstream digital markets like eBay. The Silk Road was closed down in 2013 and its second iteration, along with 400 other deep web sites, were taken down in 2014. It is not clear yet how this disruption has affected the organisation of this market but it would appear that, following a period of increasing openness, the dark web is becoming increasingly closed and is often used as a means to facilitate one-to-one interactions between a seller and buyer looking for a secure supply.

Judith Aldridge and David Décary-Héty investigated the Silk Road before it was taken down and describe how they see the sale of drugs on the dark web impacting on the global drugs trade. They argue that, while currently online exchange comprises a tiny fraction of the overall drugs trade, it has the capacity to complement conventional trade by allowing the purchase of a wide range of substances that would not be available otherwise. The need to become adept at TOR-like technology, security fears and the degree of planning required may be limiting factors on the growth of this market. The removal of the threat of both violence and arrest may encourage greater use and growth is more likely if the recent pattern of disruption of cryptomarkets without

significant arrest continues. As in the conventional market, vendor reputation is important and John Cox explains how vendors need to score well on a sophisticated rating system if they are to establish themselves in this market.

Eileen Ormsby studied the Silk Road for many years and presents her insights into the motives, political outlook and concerns of those who administered it or engaged in this cryptomarket as buyers or sellers. As happens in conventional markets this type of virtual market presents opportunities for harm reduction interventions. The experience of a medical doctor providing advice to users of online drug markets are recounted in a separate chapter.

Enforcement and monitoring

Two chapters examine the criminal aspects of dark net markets, the nature of supply and trafficking online and the efforts of law enforcement to counter illegal activity in this sphere. A chapter on the I-TREND (Internet Tools for Research in Europe on New Drugs) project describes a method for monitoring online NPS shops using specially designed software which builds on the snapshot studies conducted in this area since 2012. The project identified 584 online shops, 18 per cent of which were duplicates designed to distract attention from the original site. It is a very dynamic market which is difficult to monitor, but improvements in method indicate a considerable expansion in reliable data on use, retailers' marketing approaches and the survival rates of such online enterprises.

Emerging issues

Technological innovations in encryption, digital currencies and browsing are key drivers of change in online drug markets. These facilitate anonymity for the seller, from both organised and 'disorganised' crime sectors, and for the buyer, as well as greatly reducing the risk of harm from violence as those involved in transactions do not have to meet.

Social activism and the personal benefits of membership of an online community attract a wide audience to the user forums and discussion boards which gather around cryptomarkets and expand the potential pool for buyers of products online. The popularity of this social media, and the willingness of those who contribute to them to offer advice, opinion and provide important market feedback, present a rich opportunity to research this environment and provide a greater understanding of the operation of the dark web.

This type of research will be relevant not just for uncovering the mechanisms of the market itself but for providing insights into how the existence of these markets affects drug use and the consequences of this use. These concerns and the manner in which the internet may provide both expansion of supply and opportunities for harm reduction interventions will probably be the focus of research in this area in the coming years.

Brian Galvin

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The drugs market and intimidation

We know from several international studies that the basic assumptions of the standard economic model do not apply to the market for illicit drugs.¹ The existence of this market has consequences, often violent, for the distributors and buyers engaged in it as well as for the broader community. Earlier this year the nature of the intense rivalry among those involved in the importation and distribution of illicit drugs was underlined by a number of very public violent incidents in Dublin. The seemingly inevitable lethal outcome of disputes among competitors in this market receives a great deal of media attention, including profiles of prominent victims and background stories on how this usually clandestine business operates.

A hidden but more frequently occurring harm is the violence and threat of violence experienced by drug users and their families within their own communities as a result of debt incurred through drug use. The willingness of distributors to use or threaten violence to enforce debts or overcome obstacles has a profound impact on communities already dealing with the disorder and property crime resulting from the concentration of drug markets in their areas.² Intimidation, by its nature, uses fear to both force people into certain actions and ensure silence. It is therefore a very difficult topic to study and while anecdotally we know intimidation is used intensively in certain communities, the extent of its use and the consequences for the victims have not been systematically measured.

A recent CityWide study, *Demanding money with menace*,³ recorded and categorised incidents reported to community-based drug services which have not, generally, come to the attention of the Garda. This research built on the knowledge obtained through two previous studies, which had used innovative approaches to illuminate the nature and consequences of this phenomenon.

Intimidation of families

A 2009 report on drug-related intimidation, published by the Family Support Network (FSN),⁴ put the findings in the broader context of families already living in marginalised communities and undergoing further alienation as a result of official indifference and even hostility. Having a family member being threatened with, or actually experiencing, violence as a result of drug use was found sometimes to elicit little sympathy from statutory agencies, leaving affected families to cope on their own. While communities often organised themselves in a collective response to the open sale of drugs in certain areas, the author of the report described how drug users themselves were sometimes targeted by this communal activism, compounding their already difficult situation. From their work with families of deceased drug users FSN was well placed to articulate concerns around the specific problem of drug-related intimidation and explore means of alleviating its worst effects on the communities in which criminal organisations were active.

Following an initial study using a Garda-designed research tool, the author of the 2009 report undertook a postal survey of a sample of 91 family support workers or facilitators, 50 of whom responded. The survey gathered information on the extent and nature of drug-related intimidation encountered by the respondents in the course of their work over the previous 12 months. The responses included case studies submitted by 36 respondents. Nearly all the respondents reported that they had clients, usually mothers of indebted drug users, but also including other family members, who had experienced intimidation because of drug-related debts, sometimes as low as €100 but more often amounting to several thousand euro. Little account had been taken of the capacity of these people to repay the debts, with most families needing to take out loans or sell property to do so. Nevertheless, payment was pursued relentlessly and participation in illegal activity, such as storing drugs or weapons or even prostitution, was often accepted as partial payment. This enforced criminality sometimes resulted in the exclusion of the family from their local authority home. Mothers were the family member most frequently targeted by those seeking repayment of a debt and it was usually an associate of the person to whom the debt was owed who made contact. Payment of the debt generally ended the intimidation, but most of the case studies reported that the drug user often incurred further debts and then the intimidation began again. The survey also collected information on the consequences of unpaid debts, with threats almost invariably being carried out.

While verbal threats, including threats of sexual violence, were the most frequently recorded form of intimidation, physical violence and damage to property were almost as common. Intimidation has a profound effect on the communities where it is prevalent. Families who had experienced intimidation were too fearful to approach the Garda and it seems drug-related intimidation is a very under-reported crime. The 2009–16 National Drugs Strategy, following a recommendation from this 2009 report, included an action (Action 5) to develop a response to the problem of intimidation. FSN, together with the Garda and the Health Service Executive (HSE), developed a framework including training, an information leaflet and an online campaign to assist drug users, their families or friends who are experiencing drug-related intimidation.

Melting the iceberg of fear

A 2013 study of drug-related intimidation concentrated on one area of a Dublin suburb, interviewing people working in various health and community services.⁵ From the responses to the interviews, the author devised a ranking system for those engaged in drug-related intimidation, starting with a 'higher order', comprising those in powerful positions in the illicit drugs market locally who organised intimidation of indebted users and other members of the community; a 'middle order', often drug users themselves, who were prepared to threaten to protect their own position or act on the instruction of others; and a 'lower order', mainly children, who were being initiated into drug dealing and engaging in antisocial behaviour at the behest of adults.

Drugs-related intimidation

continued

Demanding money with menace

The 2016 CityWide study, mentioned above, undertook an audit of drugs projects in local and regional drug and alcohol task force areas to gather information on intimidation that had been reported to these projects. Most task forces agreed to participate in the audit and collaborated with the authors in the design of the questionnaire on which the audit was based. The authors used a series of focus groups with both local and regional drugs and alcohol task forces to explain the purpose of the audit, garner local information on the subject and distribute the questionnaires. Project workers in the participating task force areas completed the questionnaires and returned them to CityWide between April 2014 and December 2015. To complete the audit the authors held further focus groups, which were used to complement and clarify the findings from the returned questionnaires. They also undertook focus groups with Travellers, former prisoners and various community groups.

The findings of the CityWide audit were similar to those of the 2009 FSN study in a number of respects. After the drug user who had incurred a debt, the person most likely to be a victim of intimidation was the debtor's mother. These were also the people most likely to report threats of, or actual, violence. The drug user was often the source of intimidation, putting pressure on his or her own family to pay money owed as result of drug use. While verbal threats formed part of three quarters of all intimidation incidents reported, physical violence (46%) and damage to property (32%) were very common. As was found in the FSN study, coercion into criminal activity often resulted from failure to pay a drug debt. As supply of drugs on credit is a feature of the illicit drug market, violence is seen not just as a means of enforcing a debt but also as a means of warning other drug users about the consequences of not paying debts. The increasingly heavy use of cannabis among young people has meant that the age profile of those incurring debts has declined. Just over 40 per cent of debts are for sums of less €1,000 but the pressure to pay relatively small debts is just as intense as for greater sums. A little over a quarter of debts were for sums of €1,000 to €5,000, with nearly 13 per cent ranging between €5,000 and €10,000.

The role played by gangs in the acquisition and distribution of drugs in marginalised communities has been documented,⁶ and intimidation, or enforcement of debt, is also frequently organised and carried out by groups of people. Most of the incidents recorded in the CityWide audit involved groups of people: existing social networks attempt to establish themselves in the drugs trade and such groupings are necessary to maintain clandestine activity. Young people are generally acquainted with those who intimidate them, often belonging to the same social network and enduring the consequences of falling into debt with friends.

The responses of victims and their families to drug-related intimidation vary, with slightly less than half of debts being paid in full. Some individuals and their families took no action while just over one in five avoided the perpetrators. A little over a third of those reporting incidents had informed the Gardaí, with community organisations being the organisations to which intimidation was most often reported. Fear of reprisal was the reason most people gave for not reporting to the Gardaí and, even if prosecution did follow, this was no guarantee that the intimidation would cease. The consequences for victims of intimidation and their families can be severe, with more than two thirds reporting mental health problems arising from both the intimidation itself and the attendant relationship problems, financial worries and stress in the workplace.

The CityWide report emphasises the role played by community services in supporting those targeted by intimidation and calls for these services to be adequately equipped to deal with these distressing situations. Young people's indebtedness can rapidly lead to criminal activity, so early preventative work and intervention to stop gang formation is also important. According to the authors, the normalisation of drug-related intimidation and the degree to which it is under-reported owing to fear and lack of confidence in the policing system are major criminal justice issues which require resources and the attention of all relevant agencies to resolve.

Brian Galvin

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RESPONSES

17th annual Service of Commemoration and Hope

On Monday 1 February 2016 the National Family Support Network (NFSN) held its 17th annual Service of Commemoration and Hope. This spiritual, multi-denominational service is held in remembrance of loved ones lost to substance misuse and related causes, and to publicly support and offer hope to families living with the devastation that substance misuse causes.

Those in attendance included President Michael D Higgins; Charlie Dineen, aide-de-camp to the Taoiseach; Aodhán Ó Riordáin TD, Minister of State with responsibility for Drugs; Joe Costello TD; Garda Commissioner Noirín O'Sullivan; Deputy Lord Mayor Cieran Perry; Bishop Eamonn Walsh and other religious representatives. Family members, friends, and many people working in the drugs area also attended. Music was provided by the soprano Nickola Hendy and the Dublin Gospel Choir.

In her address to the gathering, Sadie Grace of the NFSN spoke about the latest report from the National Drug-Related Deaths Index,¹ which shows an increase in drug-related deaths. She spoke about the increase in deaths owing to heroin use and how the majority of deaths involved young men. She also mentioned the role of naloxone in helping prevent deaths from opiate overdose and the NFSN's support for the HSE naloxone demonstration project. She stressed the importance of expanding the availability of naloxone to family members and educating families on the signs and symptoms of overdose.

Sadie spoke about the impact of compounding factors affecting bereaved families associated with drug-related deaths, such as increased financial difficulties related to funerals, and single parents or kinship carers taking on the responsibility of caring for young children. She called for more research in this area. In her closing statement she called on the audience to canvass their local TDs to ensure their political parties support the appointment of a specific minister with responsibility for the drugs strategy.

Minister Aodhán Ó Riordáin TD congratulated the NFSN on its excellent work and spoke about the current crisis in relation to drug-related deaths. He acknowledged the feeling of shame felt by drug users seeking treatment and by family members in seeking help. He spoke about this feeling of shame leading to wrongful acceptance of second-rate treatment. In his address, Bishop Eamonn Walsh spoke of the importance of moving from reliance on artificial highs to embracing natural highs through nature, sport, music, dance and the arts.



For many families, this service is the first time that they can openly grieve for their loved ones lost to drug use and related causes. The growth of family support groups was evident, with representatives from over 100 groups from across the island of Ireland represented at this year's service. Personal testimonies were given by members of family support groups, reflecting the vital support received through these groups. These included Pauline Doyle, a member of the NFSN Bereavement Support Group, who acknowledged the tremendous work of the NFSN Bereavement Support Group and encouraged family members to contact the NFSN and avail of the help it offers. The support she received helped alleviate the shame she felt and allowed her healing process to begin. Paul Grace gave a very honest and emotional speech about his experience as a drug user. He admitted feeling too ashamed to ask for help, ashamed of failure. He called for more encouragement from treatment providers to help people 'get clean' and the expansion of treatment beyond medication.

Guest speaker Elizabeth Burton-Phillips spoke about her journey of bereavement following the death of her son Nick and the publication of her book *Mum, can you lead me twenty quid?*, which is also being turned into a play. She encouraged the audience never to give up hope.

You can contact the National Family Support Network at 16 Talbot Street, Dublin 1.
Tel: 01 898 0148
email: info@fsn.ie
web: www.fsn.ie

Ena Lynn

1. Health Research Board (2015) *Drug-related deaths and deaths among drug users in Ireland: 2013 figures from the National Drug-Related Deaths Index*. Dublin: Health Research Board. <http://www.drugsandalcohol.ie/24676>

A community partnership for tackling hepatitis C

University College Dublin (UCD) and the Dublin Academic Health Centre (the Mater Hospital and St Vincent's Hospital) have successfully competed for a European Union (EU) health care award funded by the Third EU Health Programme, which focuses on implementing the EU health strategy. The successful HepCare Europe project will develop community partnerships for tackling the hepatitis C virus (HCV), which causes significant morbidity and mortality in Ireland and the EU.

The HepCare Europe project, submitted by Dr Jack Lambert (Mater Hospital) and Professor Walter Cullen (UCD School of Medicine), was approved in December 2015. It was the only successful application among four made under this call from across Europe for proposals focusing on community HCV partnerships. It is a three-year project involving populations at risk of contracting HCV in four member states, specifically in the cities of Dublin, London, Seville, and Bucharest. HCV is a major health threat in the EU, with the complications of undiagnosed and untreated HCV leading to end-stage cirrhosis and hepatocellular carcinoma. The grant awarded to UCD, totalling approximately €1.8 million from the EU and 'in kind' contributions from Irish government health agencies, will target 'vulnerable' populations.

HCV is deemed a disease of the socially-deprived, affecting primarily those with a history of injecting drug use. Many of these patients are not accessing care for a number of reasons, including active drug use, alcoholism, mental health issues and homelessness. In the last two years a medical revolution has seen the development of HCV drugs, called direct-acting antivirals, which can cure almost all those who receive an evaluation and treatment. Treatment consists of one or two pills administered orally each day for a period of often just 12 weeks. The treatment has

led to cures and reversals among those with advanced HCV-related liver disease.

The HepCare Europe project will focus on providing 'integrated care', a new model for HCV treatment based on a partnership between secondary caregivers (the Hepatology and Infectious Diseases Services at the Mater and St Vincent's hospitals) and primary caregivers, i.e. GPs and drug treatment centres in Dublin. The project will reach out to drug users and:

- identify those not accessing care, by using rapid HCV testing;
- provide peer support (using community-based organisations) to assist those identified with HCV to access care; and
- develop nurse liaison links so that the secondary caregivers will go to the patient, rather than the patients going to the secondary caregivers.

Patients will be tested in the community and have their HCV evaluated in the community by means of a novel fibroscan test, which has replaced liver biopsy, to assess the degree of hepatic impairment caused by HCV, and community-based treatments will be piloted. Other supports to patients will include interventions to help reduce or cease alcohol consumption, which is a significant problem among these vulnerable individuals.

In addition to outreach, the project will involve education of caregivers and patient groups about HCV and the new curative treatments available. The University of Bristol in the UK, an institution that has championed cost-effectiveness studies and evaluations of interventions in HIV and HCV, are partners in the Hepcare Europe project, and will provide cost-effectiveness evaluations of the interventions planned as part of this EU-funded project.

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Take-home naloxone

This article describes some of the findings of a report *Preventing opioid overdose deaths with take-home naloxone*,¹ recently published by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Opioid users are 10 times more likely to die of an overdose than their age- and gender-matched peers.²

Data presented in the EMCDDA report indicate that between 6,000 and 8,000 drug-related deaths occur every year in Europe and that opioids account for the majority of these deaths. In Ireland in 2013, there were 203 deaths in which opioids were implicated.³ Of these 203 individuals, 93 (46%) were not alone at the time of death, suggesting that an early

intervention, such as the administration of naloxone, may act to prevent opioid-induced deaths in Ireland.⁴

Opioids and naloxone

Opioids are highly addictive compounds that reduce pain by binding to their receptors in the brain and body, and by reducing the intensity of pain signals reaching the brain. A side-effect of opioid use is reduced breathing capacity, i.e. respiratory depression.

Naloxone is a semi-synthetic drug, which prevents opioids from binding to opioid receptors in the brain and body, and reverses respiratory depression. Naloxone is capable of reversing respiratory depression within one to two minutes if administered intravenously; with intramuscular or subcutaneous delivery, the effect takes longer, typically three to four minutes. In order to make naloxone use more user-friendly for non-medically trained individuals, alternative routes of administration have been explored. Intranasal (in the nose) preparations and buccal (in the

Take-home naloxone continued

mouth, against the cheek) are being assessed for their efficacy and may be more suitable for naloxone use in a non-clinical setting.

Risk of overdose

People with an opioid dependency are the group most likely to experience an overdose. Risk factors for opioid overdose include:

- injecting opioids,
- loss of tolerance,
- using opioids in combination with sedatives,
- recent release from prison,
- discharge from a residential rehab/detox, and
- using alone.

History of naloxone use

Since its discovery in the 1970s naloxone has been widely used in hospitals to reverse the effects of opioids. In the 1990s, paramedics in the US were trained to use naloxone in suspected opioid overdoses outside of the clinic, in a bid to decrease opioid-associated deaths in the community. In one urban setting, a study revealed that 90–94 per cent of the 487 individuals who received paramedic-delivered naloxone treatment responded rapidly, indicating that naloxone was a quick and effective treatment for opioid overdose in the community.

Despite the fact that there have been over 40 years of data and experience on naloxone use in a medical setting, the concept of take-home naloxone is relatively new. An increase in opioid-induced deaths in Chicago in the early to mid-1990s spurred the Chicago Recovery Alliance (CRA) to commence an informal take-home naloxone programme in 1996. This is the first known established provision of take-home naloxone. The CRA trained service users in overdose prevention and provided them with take-home naloxone kits. Owing to the demand for the service, in 2001 CRA formalised the programme and standardised the training. Similar programmes were set up in Germany, Italy and the UK in the late 1990s.

Training for take-home naloxone

Data from a report published by the WHO in 2014 showed that many opioid overdoses occurred in the presence of other people. Based on this, three target groups for training in administering take-home naloxone were identified: (1) opioid users, (2) close family and friends and (3) services that interact with opioid users. Opioid users were the primary focus of many training programmes owing to the fact that they have a 50–70 per cent lifetime risk of having an overdose and also because they are likely to be a bystander at an overdose.³

International research has found high levels of support among opioid users for take-home naloxone. However, opioid users have also expressed several concerns. These include questions about competency when administering naloxone in the event of an overdose, the legal repercussions regarding the carrying and use of naloxone, and anxieties about either those they have treated or they themselves experiencing withdrawal symptoms. The authors of the EMCDDA take-home naloxone report recommend that concerns should be addressed when

establishing take-home naloxone programmes. Overall, data in the EMCDDA report suggest that opioid users and their families are receptive to participating in take-home naloxone programmes.

Legal issues

The legality of administering naloxone to someone other than the person it was prescribed for has been a dominating issue. Both professionals and service users have expressed concern about the risk of civil or criminal prosecution. The United States, Germany, the Netherlands, Luxembourg and the UK have passed versions of 'Good Samaritan' law, which absolves the person in the event of administering naloxone to save a life. In Italy, naloxone is available over the counter so is not subject to legislation regarding prescription.

Take-home naloxone in Europe and in Ireland

In 2014 data were presented at an EMCDDA meeting in Lisbon regarding take-home naloxone use in Europe.⁵ Among the 24 member states who responded, naloxone was available on medical prescription in 13 and limited to hospital-only prescription in a further 11 countries. None of the 24 responding countries currently had a national take-home naloxone programme. However, programmes existed in cities or regions across Europe, including Denmark, Germany, Ireland, Italy, Norway, Spain and the UK, and data from these studies are expected to prompt nation-wide programmes in some countries. Outside Europe, there are take-home naloxone programmes available in the USA, Australia, Canada and Russia.

In Ireland in May 2015, the Health Service Executive (HSE) established a take-home naloxone project that will assess the efficacy of take-home naloxone in preventing drug-induced deaths, with an initial target of 600 participating opioid users. Participants are required to learn by video-training about overdose signs, risk factors, administration of naloxone, and basic life support. If knowledge of these can be shown, the participant is given a take-home naloxone kit.

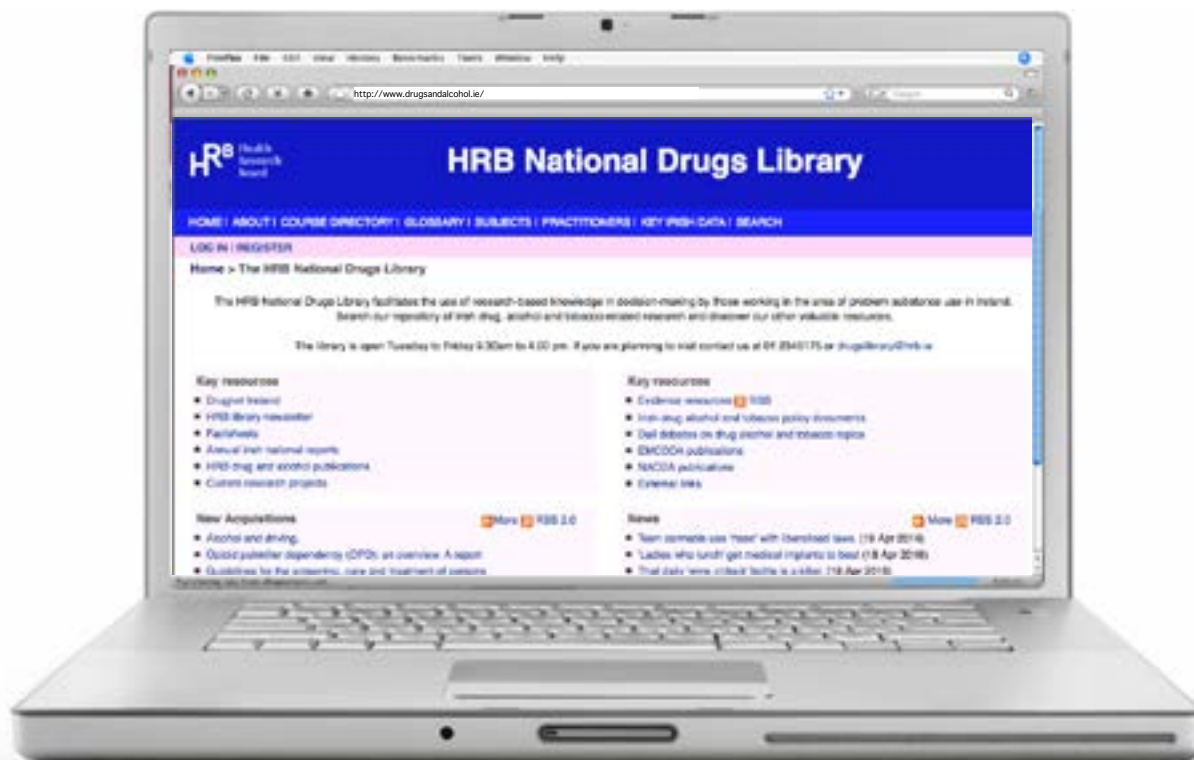
Looking to the future, it is strongly recommended that take-home naloxone programmes and the rate of associated overdose mortality be rigorously monitored in order to adequately evaluate its success, sustainability and cost effectiveness. No evaluation data relating to the HSE's project are available yet.⁶

Aoife Cannon

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6. For more information on the HSE take-home naloxone project, visit <http://www.drugs.ie/resources/naloxone>

SERVICES

HRB National Drugs Library



To coincide with the launch of the Health Research Board's new strategy, the National Documentation Centre on Drug Use changed its name to the **HRB National Drugs Library** in January 2016. We have refreshed our website www.drugsandalcohol.ie to reflect this change.

We continue to provide the same range of resources and services to facilitate the use of research in decision-making by those working in the area of problem substance use.

There are a number of easy ways in which you can keep up-to-date:

- Follow us on **Twitter** @HRBdrugslibrary, or sign up to receive links to new research straight to your email account.
- Read our quarterly research and policy bulletin, **Drugnet Ireland**, which provides summaries of recent Irish policy developments, events and research.
- Sign up to our monthly **electronic newsletter** with links to new publications, Dáil debates and news items.

Those working in the drugs area will be aware that drug-related research is highly complex, primarily rooted in physical and mental health, but also incorporating other areas such as criminal and social justice, social science, and education.

You can search our entire collection of Irish and international research using our simple or advanced search facilities. And our **practitioner resource** provides direct links to key documents and subjects relevant to health and social-care professions.

If you are looking for up-to-date Irish data, you may be particularly interested in our interactive **drug-treatment** and **alcohol-diary data tables**, found on the **key Irish data** page. Also on that page, you can access our factsheets on cannabis, cocaine, sedatives and opiates.

And our very first alcohol factsheet, compiled by the librarians, was recently published. **Alcohol: the Irish situation** draws together information on treatment, prevalence, mortality and crime in Ireland in one convenient document.

As librarians, we have a significant role to play in facilitating knowledge transfer and exchange. Throughout the research process we can provide relevant resources and services, culminating in the effective dissemination and use of findings. We will continue to engage with researchers and practitioners to achieve this ultimate goal.

Mairea Nelson and Mary Dunne

Coolmine launches new strategy 2016–2018



Pauline McKeown Coolmine CEO, Joan Burton TD and Alan Connolly, Coolmine chair at the launch of Coolmine strategic plan 2016 – 2018

The Tánaiste, Joan Burton TD, launched Coolmine Therapeutic Community's (CTC's) new strategy for 2016 to 2018 in the offices of Dublin City Council on 16 December 2015.¹ Acknowledging the impressive amount of work that had gone into the development of the strategy, she observed that at the heart of a successful plan is interagency co-operation in health, housing and social services. She specifically mentioned CTC's Parents under Pressure Programme at Ashleigh House, the only family residential service in Ireland.

Alan Connolly, chairman of Coolmine, and Pauline McKeown, CEO, also spoke, outlining the process of developing, and the objectives of, the new strategy.² The new strategy contains 12 objectives under two overarching strategic aims.

Growth and innovation

- Develop a drug-free prison therapeutic community to increase the service provision for prisoners with problematic substance misuse issues in the Irish Prison Service.
- Scope out and develop the expansion of CTC's mother and child services, including further programmes for non-stabilised pregnant women and the Parents under Pressure programme.
- Develop services to enhance treatment access, decrease early leavers and manage crises during lapse/relapse.
- Explore the potential for further non-residential community-based alcohol treatment services.
- Review and enhance partnership agreements to further increase access to treatment and rehabilitation services, support project expansion and maximise after-care supports nationally.
- Invest in CTC's established research culture to identify opportunities that contribute both national and internationally.

Capacity and sustainability

- Identify and invest in staff and management structures.
- Conduct an annual review of governance arrangements, including clinical governance, charity regulation, and fund-raising principles.
- Develop comprehensive IT systems.
- Develop an annual maintenance plan for each service that reflects best practice in health and safety, is cost-effective and deliverable.
- Devise and deliver a communications strategy to enhance the national profile of the organisation and to secure CTC's position as a treatment and rehabilitation centre of excellence.
- Develop and implement a three-year fund-raising strategy incorporating realistic income targets, sustainable growth and targeting opportunities locally, nationally and internationally.

Graduates of the Coolmine programme, Ann Marie Sweeney and Charles Lane, spoke eloquently about their journey with Coolmine and how engaging with treatment had helped to turn their lives round. Ann Marie is heading to college and Charles is now the client co-ordinator at Coolmine.

Further information can be found at www.coolmine.ie

Suzi Lyons

1. Coolmine Therapeutic Community (2015) *Coolmine strategic plan 2016–2018*. Dublin: Coolmine Therapeutic Community. <http://www.drugsandalcohol.ie/24927/>
2. Videos of the speakers can be found at http://www.drugs.ie/multimedia/video/launch_coolmine_strategic_plan_2016_20182

HSE national service plan 2016

The HSE's National Service Plan 2016 (NSP), approved by the government in December 2015, sets out the HSE's priorities and targets for tackling tobacco use and alcohol and substance misuse in 2016.¹ Initiatives are identified in three distinct areas – in the context of the Healthy Ireland policy framework, and within the HSE's Primary Care Division and Mental Health Services.

Healthy Ireland framework²

The key priorities and actions for tobacco and alcohol are listed under the goal of 'promoting health and well-being as part of everything we do so that people will be healthier' (pp. 45–49).

Tobacco

- Maintain and strengthen the HSE Tobacco Free Policy
- Maximise impact of the QUIT Campaign
- Make all new residential units tobacco-free
- Train frontline workers to support smokers to quit

2016 Quality Indicator: 45 per cent of smokers on cessation programmes quit at one month.

2016 Access Indicator: 11,500 smokers received intensive cessation support from a cessation counsellor.

Alcohol

- Develop a three-year alcohol implementation plan to reduce alcohol consumption and related harms, incorporating actions from the National Substance Misuse report³ and aligned to new legislation.
- Develop and prepare the enforcement provisions of the Public Health (Alcohol) Bill 2015 in partnership with the Department of Health.
- Further progress a co-ordinated approach to prevention and education interventions through the community mobilisation on alcohol initiatives with drugs and alcohol task forces, and through the REACT award and accreditation scheme in the third-level sector, which recognises and rewards an institution's efforts to reduce alcohol-related harm amongst its students.
- Increase awareness among the public of alcohol-related harm by building on the 2015 communication campaign.

Primary care

Smoking and alcohol and illicit substance misuse are all addressed by the HSE's Primary Care Division, which is responsible for primary teams (PCTs) and general practice, primary care reimbursement schemes (PCRS), social inclusion and palliative care services.

Smoking

As part of collaboration between Primary Care and Health and Wellbeing for Health, PCTs are to support brief intervention training for staff on smoking cessation (p. 54).

Methadone treatment

Methadone treatment is one of a number of primary care reimbursement services (PCRS). These PCRS are delivered by over 7,000 primary care contractors such as general practitioners, pharmacists, dentists, optometrists and/or ophthalmologists, who are reimbursed by the HSE. A key priority and action for 2016 relevant to methadone treatment is the implementation of the plan for the roll-out of individual health identifiers in 2016 in line with the Health Identifiers Act 2014 (p. 56).

Addiction and substance misuse

Addiction services are provided by Social Inclusion Services, the core objective of which is to improve health outcomes for the most vulnerable in society including Irish Travellers and Roma, asylum seekers, refugees and lesbian, gay, bisexual, transgender (LGBT) service users. Issues of addiction, substance misuse, homelessness and domestic, sexual and gender-based violence are overarching themes within the service user groups. Social Inclusion Services work with mainstream services and voluntary sector services to ensure accessibility for disadvantaged service users.

The priorities and key actions to improve health outcomes for people with addiction issues include the following (p. 56):

- implement the outstanding actions in the *National Drugs Strategy* (2009–2016);⁴
- ensure that adults deemed appropriate for treatment for substance abuse receive treatment within one calendar month;
- ensure that children deemed appropriate for treatment for substance abuse receive treatment within one week;
- ensure that addiction services operate within the person-centred care planning processes of the Drugs Rehabilitation Framework;⁵
- finalise the response to drug-related deaths through a National Overdose Prevention Strategy;
- audit drug services in line with the Drugs Rehabilitation Framework on care planning, assessment, key working and referrals; and
- strengthen clinical governance structures by the appointment of an Addiction Clinical Lead.

2016 access indicators (p. 63):

- Substance misusers (over 18 years) for whom treatment has commenced within one calendar month following assessment: 100%
- Substance misusers (under 18 years) for whom treatment has commenced within one week following assessment: 100%
- Number of clients in receipt of opioid substitution treatment (outside prisons): 9,515
- Average waiting time from referral to assessment for opioid substitution treatment: 14 days
- Average waiting time from opioid substitution assessment to exit from waiting list or treatment commenced: 28 days
- Number of unique individuals attending pharmacy needle exchange: 1,731

HSE national service plan continued

Community-based responses

Actions to strengthen community-based responses include (p. 59):

- development and distribution of standardised problem alcohol and substance use screening and brief intervention SAOR (Support, Ask and Assess, Offer Assistance and Refer) toolkits to support Tier 1 and Tier 2 services, and
- publication of a Guiding Framework for Education and Training in Screening and Brief Intervention for Problem Alcohol Use for nurses and midwives in acute, primary and community settings.

The aim is to roll out SAOR screening and brief intervention training to 300 staff for problem alcohol and substance use within Tier 1 and Tier 2 services, and to deliver 30 SAOR trainings and complete four train-the-trainer programmes nationally.

To strengthen community development approaches in line with the Healthy Ireland framework, Social Inclusion Services are also to establish a social inclusion working group on community development, to incorporate principles in respect of addressing health inequalities, community development, community participation, social prescribing etc. with a focus on vulnerable communities (p. 59).

Mental health

The mental health service, integrated with other areas of the wider health service, extends from promoting positive mental health and suicide prevention through to supporting those experiencing severe and disabling mental illness. It includes specialised secondary care services for children and adolescents, adults, older persons and those with an intellectual disability and a mental illness. The 10-year national policy, *A Vision for Change*,⁶ continues to inform the roadmap, charting the way forward for the mental health service.

Among the priorities for Mental Health in 2016 is the development of a new clinical programme specifically for dual diagnosis of mental illness and substance misuse including alcohol (p. 65).

Among measures to contribute to promoting the mental health of the population in collaboration with other services and agencies, including reducing loss of life by suicide, is an action to 'develop an increased focus on the health and wellbeing of the population in the delivery of mental health services, including supporting the continued rollout of the Tobacco Free Campus policy' (p. 65).

Brigid Pike

1. Health Service Executive (2015) *National service plan 2016*. Dublin: Health Service Executive. <http://www.drugsandalcohol.ie/24939/>
2. Department of Health (2013) *Healthy Ireland: a framework for improved health and wellbeing 2013–2025*. Dublin: Department of Health. <http://www.drugsandalcohol.ie/19628/>
3. Department of Health (2012) *Steering group report on a national substance misuse strategy* Dublin: Department of Health. <http://www.drugsandalcohol.ie/16908/>
4. Department of Community, Rural and Gaeltacht Affairs (2009) *National Drugs Strategy (interim) 2009–2016* Dublin: Department of Community, Rural and Gaeltacht Affairs. <http://www.drugsandalcohol.ie/12388/>
5. Working Group on Drugs Rehabilitation (2007) *National drugs strategy 2001–2008: rehabilitation. Report of the Working Group on Drugs Rehabilitation, May 2007* Dublin: Department of Community, Rural and Gaeltacht Affairs. <http://www.drugsandalcohol.ie/6267/>
6. Expert Group on Mental Health Policy (2006) *A vision for change: report of the Expert Group on Mental Health Policy* Dublin: Stationery Office. <http://www.drugsandalcohol.ie/6154/>

The service plan is designed to place people at the centre of the services we provide and to help improve the overall health of the population, no matter where people live, what stage of life they are at, or what their healthcare needs may be.

Tusla priorities for 2016

On 10 December 2015 Gordon Jeyes, the Chief Executive of TUSLA, the Child and Family Agency, appeared before the Joint Oireachtas Committee on Health and Children¹ to give an update on TUSLA's activities in 2015 and its priorities for 2016 (Table 1). The update reported progress in implementing TUSLA's first corporate plan, which was launched in February 2015.²

Table 1: Tusla's corporate targets for 2017 – progress in 2015 and priorities for 2016³

Output targets, 2017	Progress in 2015	Priorities in 2016
A. Tusla's child protection processes and systems are responding to children at risk in a timely fashion	<ul style="list-style-type: none"> • Child Protection Notification System (CPNS) available to external services • National Out-of-Hours Service is operational • Integrated performance reports being published quarterly on web site • Early-warning Need-to-Know system refined and agreed with Department of Children & Youth Affairs 	<ul style="list-style-type: none"> • Ahead of commencement and implementation of revised Children First guidelines, a National Implementation Team will be ensuring readiness for mandated reporting systems and responses, by preparing information and guidance for those carrying out this work, training and e-learning, and a full range of information and advice. • Revision of national after-care policy and preparation of new statutory provisions to ensure all eligible young people have a statutory right to an aftercare plan. • Ahead of Adoption (Information and Tracing) Bill, three working groups will ensure full public awareness, assessment of compelling reasons and establishment of adoption information register. • A plan will be developed to tackle resource deficits, e.g. unallocated cases, and time lags between referrals and assessments. • National Incident Management System (NIMS) will be rolled out. • Quality Assurance directorate will ensure full implementation of Tell Us at Tusla and the NIMS complaints module.
B. All services, processes and systems underpinning children and family policy are evidence-informed.	<ul style="list-style-type: none"> • National Policy catalogue developed and accessible by all Tusla staff • Draft Quality Assurance Framework developed • Research strategy approved and national operating model agreed 	<ul style="list-style-type: none"> • Policy development will become standardised through establishment of National Policy Oversight Group. • Child Protection and Welfare Handbook will be reviewed. • Family Support Services will be further developed through recruitment, training and implementation of an audit tool for family support. • A Research Ethics Committee will be established and a research needs analysis completed. • Draft Quality Assurance Framework will be piloted in Q1.

Tusla priorities continued

Table 1: Tusla's corporate targets for 2017 – progress in 2015 and priorities for 2016³

Output targets, 2017	Progress in 2015	Priorities in 2016
C. Provision of a targeted range of family-orientated supports	<ul style="list-style-type: none"> Resourcing framework for supporting parents agreed, co-ordinators in place and support materials launched Alternative care strategy is being refined Shifting from a grants system to a commissioning strategy System in place for national oversight of all services relating to domestic, sexual and gender-based violence (DSGV) Family Resource Centres now a recognised participant in service delivery framework 	<ul style="list-style-type: none"> Through Children and Young People Services Committee, local needs and priorities will inform the allocation of funding. Children in Care multi-disciplinary teams will be expanded to provide for four regional teams with enhanced capacity to support children in care with challenging behaviour. An Alternative Care Strategy will be developed, including new metrics, and a Children in Care to Adoption Handbook will be developed. A Commissioning Support Unit and annual commissioning cycle will be developed. DSGV services – governance and oversight with standard reporting framework for services will be implemented, and information capability to support delivery of services will be developed.
D. Attendance, participation and retention in full-time education is embedded in service delivery.	<ul style="list-style-type: none"> Integrated service management structure approved and national lead managers being appointed School Completion Programme (SCP) reviewed Early-years inspection registration managers are in place and national governance structure established 	<ul style="list-style-type: none"> The community strengths of the SCP will be built on, and an integrated approach to educational welfare, home school liaison and school completion will be pursued. Early Years Inspectorate will develop and implement new processes and systems in respect of new regulations. A Central Registration Office will be established and an ICT system developed to support intelligence-driven inspections. A review of Section 14 assessments for those educated at places other than school will be completed. Participation and achievement in education of all children in care will be the focus of specific monitoring.

Brigid Pike

1. Joint Oireachtas Committee on Health and Children (2015, 10 December) *Update on Child and Family Services: Tusla*. Retrieved 27 January 2016 <http://oireachtasdebates.oireachtas.ie/debates%20authoring/debateswebpack.nsf/committeetakes/HEJ2015121000002?opendocument#C00100>
2. Tusla – Child and Family Agency (2014) *Corporate plan 2015 –2017* Dublin: Tusla. <http://www.drugsandalcohol.ie/23497/>
See also B Pike (2015) Tusla publishes first corporate plan *Drugnet Ireland* (54): 22–23 <http://www.drugsandalcohol.ie/24236/>
3. Jeyes G (2015, 10 December) *Opening statement to Joint Committee on Health and Children*. Retrieved 27 January 2016 <http://www.tusla.ie/news/opening-statement-to-joint-committee-on-health-and-children>

UPDATES

Recent publications

The following abstracts are cited from recently published journal articles relating to the drugs situation in Ireland.

Changes in psychological well-being among heroin-dependent adolescents during psychologically supported opiate substitution treatment

Smyth BP, Ducray K and Cullen W (2016) *Early Intervention in Psychiatry*, Early online.
<http://www.drugsandalcohol.ie/25117/>

Heroin-dependent adolescents demonstrate high rates of comorbid psychological problems. Among heroin-dependent adults, opiate substitution treatment (OST) programmes appear to reduce mental health problems. We sought to examine the impact of OST on psychological well-being in adolescents, as this is unknown. We conducted a prospective study examining psychological well-being in heroin dependent adolescents, aged 18 years or younger, engaged in outpatient psychologically supported OST. Patients were treated with either methadone or buprenorphine. This was complemented with individual key working, counselling (motivational interviewing and cognitive behavioral therapy) and group work focusing on life skills. The Beck Youth Inventory was used to measure psychological well-being at treatment entry and repeated after 4 months of treatment.

Among 55 consecutive treatment episodes, we examined the 32 episodes where the patient persisted with the OST programme. Polysubstance use was the norm at treatment entry. At follow-up, the median doses of methadone and buprenorphine were 50 mg and 8 mg, respectively. Only three patients were treated with antidepressant medication. There was significant improvement in the mean depression (65.0 to 57.9, $P = 0.001$), anxiety (61.7 to 57.0, $P = 0.006$) and anger (57.8 to 54.6, $P = 0.009$) subscale scores. The self-concept and disruptive behaviour subscale scores did not improve significantly. In this relatively short-term follow-up, psychosocially assisted OST appears to be associated with improved psychological well-being in heroin-dependent adolescents, especially in the area of depressive and anxiety symptoms.

The injecting use of image and performance-enhancing drugs (IPED) in the general population: a systematic review

Brennan R, Wells JSG and Van Hout MC (2016) *Health and Social Care in the Community*, Early online.
<http://www.drugsandalcohol.ie/25116/>

Injecting use of image and performance-enhancing drugs (IPED) in the general population is a public health concern. A wide and varied range of IPED are now easily accessible to all through the online market. A comprehensive literature review was undertaken according to Critical Appraisal Skills Programme (CASP) guidelines for systematic review, to identify the relevant literature. No date restrictions were placed on the database search in the case of human growth hormone melanotan I and II, and oil and cosmetic injectables. In the case of anabolic androgenic steroids search dates were restricted to January 2014–2015. Publications not in English and with a lack of specificity to the topic were excluded. The review yielded 133 relevant quantitative and qualitative papers, clinical trials, clinical case presentations and editorials/reports. Findings were examined/reviewed under emergent themes which identified/measured extent of use, user profiling, sourcing, product endorsement, risk behaviours and health outcomes in users. Motivation for IPED use may be grounded in appearance, pursuit of health and youth, and body image disturbance. IPED users can practice moderated use, with pathological use linked to high-risk behaviours, which may be normalised within IPED communities. Many IPED trajectories and pathways of use are not scientifically documented. Much of this information may be available online in IPED specific discussion forums, an underutilised setting for research, where uncensored discourse takes place among users. This review underscores the need for future internet and clinical research to investigate prevalence and patterns of injecting use, and to map health outcomes in IPED users. This paper provides community-based clinical practice and health promotion services with a detailed examination and analysis of the injecting use of IPED, highlighting the patterns of this public health issue. It serves to disseminate updated publication information to health and social policy makers and those in health service practice who are involved in harm reduction intervention.

Seventeen year mortality in a cohort of patients attending opioid agonist treatment in Ireland

Klimas J, Keane A, Cullen W, O'Kelly F and Bury G (2016) *The European Journal of General Practice*, Early online. pp. 1–2
<http://www.drugsandalcohol.ie/24856/>

Commentary on 'Methadone-maintained patients in primary care have higher rates of chronic disease' by O'Toole et al., *European Journal of General Practice* 2014 (20): 275–80

Over-the-counter codeine – from therapeutic use to dependence, and the grey areas in between

Clyne B, Nielsen S and Van Hout MC (2016) *Current Topics in Behavioral Neurosciences*, Early online
<http://www.drugsandalcohol.ie/25048/>

Codeine is a widely used analgesic, that is available for sale in pharmacies over the counter (OTC) in a number of countries including the UK, South Africa, Ireland, France and Australia. In these countries with OTC codeine sales there have been emerging concerns about misuse of and dependence on codeine containing combination analgesics, with increasing numbers of people presenting for help with codeine dependence at primary care and addiction treatment services. This has led to many countries to review availability of codeine in OTC available preparations, and to consider possible measures to reduce harms from misuse of OTC codeine containing combination analgesics.

Injection of new psychoactive substance snow blow associated with recently acquired HIV infections among homeless people who inject drugs in Dublin, Ireland, 2015

Giese C et al. (2015) *Euro surveillance: bulletin Européen sur les maladies transmissibles* [European communicable disease bulletin] 20 (40)
<http://www.drugsandalcohol.ie/25015/>

In February 2015, an outbreak of recently acquired HIV infections among people who inject drugs (PWID) was identified in Dublin, following similar outbreaks in Greece and Romania in 2011. We compared drug and risk behaviours among 15 HIV cases and 39 controls. Injecting a synthetic cathinone, snow blow, was associated with recent HIV infection (AOR: 49; $p = 0.003$). Prevention and control efforts are under way among PWID in Dublin, but may also be needed elsewhere in Europe.

Recent publications continued

Case-control study of risks and causes of death amongst opioid dependent patients on methadone maintenance treatment

Truszkowska E, McCarron P, Konovalov P, Galander T, Lyons S, Keenan E and Smyth BP (2015) *The Canadian Journal of Addiction* 6 (3): 17–26
<http://www.drugsandalcohol.ie/25004/>

This article is discussed in detail on pages 5 and 6 of this issue.

Personality and substance use: psychometric evaluation and validation of the Substance Use Risk Profile Scale (SURPS) in English, Irish, French, and German adolescents

Jurk S *et al.* (2015) *Alcoholism Clinical and Experimental Research* 39 (11): 2234–2248
<http://www.drugsandalcohol.ie/25004/>

The aim of this present longitudinal study was the psychometric evaluation of the Substance Use Risk Profile Scale (SURPS). The authors analyzed data from N=2,022 adolescents aged 13 to 15 at baseline assessment and 2 years later (mean interval 2.11 years). Missing data at follow-up were imputed (N=522). Psychometric properties of the SURPS were analyzed using confirmatory factor analysis. We examined structural as well as convergent validity with other personality measurements and drinking motives, and predictive validity for substance use at follow-up.

The hypothesized 4-factorial structure (i.e. anxiety sensitivity, hopelessness, impulsivity [IMP], and sensation seeking [SS]) based on all 23 items resulted in acceptable fit to empirical data, acceptable internal consistencies, low to moderate test-retest reliability coefficients, as well as evidence for factorial and convergent validity. The proposed factor structure was stable for both males and females and, to lesser degree, across languages. However, only the SS and the IMP subscales of the SURPS predicted substance use outcomes at 16 years of age.

The SURPS is unique in its specific assessment of traits related to substance use disorders as well as the resulting shortened administration time. Test-retest reliability was low to moderate and comparable to other personality scales. However, its relation to future substance use was limited to the SS and IMP subscales, which may be due to the relatively low-risk substance use pattern in the present sample.

Vulnerable families and drug use: examining care admissions of children of parents attending an Irish drug treatment facility

McGivern A and McDonnell C (2015) *The Irish Social Worker* (Spring): 17–23
<http://www.drugsandalcohol.ie/24712/>

Harmful substance use has a detrimental effect on parenting, and child welfare agencies consistently confirm such usage as a primary factor in initial referral. This article examines the circumstances of child admissions to care over a nine year period, from families where one or both parents attend a centralized drug treatment services. A recurrent theme during the study period was low rates of family reunifications within a twelve month period. Furthermore, we identified factors which in the view of natural parents and the service social work team have contributed significantly when families have been reunited.

Low resolution and high resolution MS for studies on the metabolism and toxicological detection of the new psychoactive substance methoxypiperamide (MeOP)

Meyer MR, Holderbaum A, Kavanagh P and Maurer HH (2015) *Journal of Mass Spectrometry* 50 (10): 1163–74
<http://www.drugsandalcohol.ie/24617/>

In 2013, the new psychoactive substance methoxypiperamide (MeOP) was first reported to the European Monitoring Centre for Drugs and Drug Addiction. Its structural similarity to already controlled piperazine designer drugs might have contributed to the decision to offer MeOP for online purchase.

The aims of this work were to identify the phase I/II metabolites of MeOP in rat urine and the human cytochrome P450 (CYP) isoenzymes responsible for the initial metabolic steps. Finally, the detectability of MeOP in rat urine by gas chromatography-mass spectrometry (GC-MS) and liquid chromatography coupled with multistage mass spectrometry (LC-MS(n)) standard urine screening approaches (SUSAs) was evaluated. After sample preparation by cleavage of conjugates followed by extraction for elucidating phase I metabolites, the analytes were separated and identified by GC-MS as well as liquid chromatography-high resolution-tandem mass spectrometry (LC-HR-MS/MS). For detection of phase II metabolites, the analytes were separated and identified after urine precipitation followed by LC-HR-MS/MS. The following metabolic steps could be postulated: hydrolysis of the amide, N-oxide formation, N- and/or O-demethylation, oxidation of the

piperazine ring to the corresponding keto-piperazine, piperazine ring opening followed by oxidation of a methylene group to the corresponding imide, and hydroxylation of the phenyl group. Furthermore, N-acetylation, glucuronidation and sulfation were observed.

Using human CYPs, CYP1A2, CYP2C19, CYP2D6, and/or CYP3A4 were found to catalyze N-oxide formation and N-, O-demethylation and/or oxidation. Mostly MeOP and N-oxide-MeOP but to a minor degree also other metabolites could be detected in the GC-MS and LC-MS(n) SUSAs.

Examining the use of community service orders as alternatives to short prison sentences in Ireland

O'Hara K and Rogan M (2015) *Irish Probation Journal*, 12, October 2015
<http://www.drugsandalcohol.ie/24883/>
 Ireland's highly discretionary sentencing system provides a rare opportunity to study the behaviour of judges when relatively free of externally imposed constraints. While this is so, few studies have investigated sentencing trends. In 2011, Ireland introduced the Criminal Justice (Community Service) (Amendment) Act 2011 requiring courts to consider imposing Community Service Orders (CSOs) in cases where sentences of less than twelve months are deemed appropriate. A CSO is a direct prison alternative requiring offenders to complete between forty and 240 hours unpaid community work in lieu of a prison term. In order to complete comparative analysis, administrative data pertaining to all cases sentenced to a short term of imprisonment or CSO between 2011 and 2012 were linked and analysed. Analysis of offence groups showed that more cases convicted of drug, public order, and robbery or related offences received Community Service than was expected; however effect sizes were small. Findings showed the average number of Community Service hours equivalent to one month of imprisonment differed by offence type and District Court jurisdiction. As the first of its kind in Ireland, this study provides a rare glimpse of the use of these two alternative criminal justice sanctions. Findings and their implications are discussed.

Coolmine Therapeutic Community, Dublin: a forty-year history of Ireland's first voluntary drug treatment service

Butler S (2015) *Addiction* Early online
<http://www.drugsandalcohol.ie/24509/>

To document the evolution over forty years (1973–2013) of Coolmine

Recent publications continued

Therapeutic Community (Ireland's first voluntary drug treatment service) against a background of broader drug policy developments in the Republic of Ireland and elsewhere during this period, data were gathered by means of archival research within Coolmine, complemented by semi-structured interviews with former clients, current and former Coolmine management and staff, and representatives of outsider stakeholder interests.

Coolmine's history has three phases: (1) an early and uncontentious phase in which external authorities provided financial support for Coolmine without questioning its work practices or outcomes; (2) a middle, controversial phase in which Coolmine struggled for survival in an external policy environment now dominated by harm reduction strategies; and (3) a final phase in which, through the use of conventional corporate governance, Coolmine management sought to repair its damaged reputation by introducing evidence-based clinical practices.

Coolmine Therapeutic Community was established when drug treatment services in Ireland were in their infancy, and its changing fortunes over subsequent decades reflected changing perceptions of what constitutes appropriate addiction treatment – and in particular the role to be played by former addicts within addiction treatment systems – as well as changing perceptions of funding relationships between statutory authorities and voluntary providers of health and social services.

The drug situation in Europe: an overview of data available on illicit drugs and new psychoactive substances from European monitoring in 2015

Mounteney J, Griffiths P, Sedefov R, Noor A, Vicente J and Simon R (2015) *Addiction* Early online
<http://www.drugsandalcohol.ie/24570/>

A central task for the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is to produce an annual report of the latest data available on drug demand and drug supply in Europe. This paper is intended to facilitate a better understanding of, and easier access to, the main quantitative European level data sets available in 2015.

The European reporting system formally covers all 28 European Union (EU) Member States, Norway and Turkey and incorporates multiple indicators alongside an early warning system (EWS) on uncontrolled new psychoactive substances (NPS). While epidemiological information is based largely on registries, surveys and other routine data reported annually, the EWS collects case-based data on an ongoing basis. The 2015 reporting exercise is centred primarily on a set of standardized reporting tools.

The most recent data provided by European countries are presented, including data on drug use, drug-related morbidity and mortality, treatment demand, drug markets and new psychoactive substances, with data tables provided and methodological information. A number of key results are highlighted for illustrative purposes. Drug prevalence estimates from national surveys since 2012 (last year prevalence of use among the 15–34 age band) range from 0.4% in Turkey to 22.1% in France for cannabis, from 0.2% in Greece and Romania to 4.2% in the United Kingdom for cocaine, from 0.1% in Italy and Turkey to 3% in the Czech Republic and the United Kingdom for ecstasy, and from 0.1% or less in Romania, Italy and Portugal to 2.5% in Estonia for amphetamine. Declining trends in new HIV detections among people who inject drugs are illustrated, in addition to presentation of a breakdown of NPS reported to the EU early warning system, which have risen exponentially from fewer than 20 a year between 2005 and 2008, to 101 reported in 2014.

Structured information is now available on patterns and trends in drug consumption in Europe, which permits triangulation of data from different sources and consideration of methodological limitations. Opioid drugs continue to place a burden on the drug treatment system, although both new heroin entrants and injecting show declines. More than 450 new psychoactive substances are now monitored by the European early warning system with 31 new synthetic cathinones and 30 new synthetic cannabinoid receptor agonists notified in 2014.

Alcohol consumption and cardiovascular disease, cancer, injury, admission to hospital, and mortality: a prospective cohort study

Smyth A *et al.* (2015) *Lancet* 386 (10007):1945–1954
<http://www.drugsandalcohol.ie/24524/>

Alcohol consumption is proposed to be the third most important modifiable risk factor for death and disability. However, alcohol consumption has been associated with both benefits and harms, and previous studies were mostly done in high-income countries. We investigated associations between alcohol consumption and outcomes in a prospective cohort of countries at different economic levels in five continents. We identified sufficient commonalities to support global health strategies and national initiatives to reduce harmful alcohol use.

We included information from 12 countries participating in the Prospective Urban Rural Epidemiological (PURE) study, a prospective cohort study of individuals aged 35–70 years. We used Cox proportional hazards regression to study associations with mortality (n=2,723), cardiovascular disease (n=2,742), myocardial infarction (n=979), stroke (n=817), alcohol-related cancer (n=764), injury (n=824), admission to hospital (n=8786), and for a composite of these outcomes (n=11,963).

We included 114,970 adults, of whom 12,904 (11%) were from high-income countries (HICs), 24,408 (21%) were from upper-middle-income countries (UMICs), 48,845 (43%) were from lower-middle-income countries (LMICs), and 28,813 (25%) were from low-income countries (LICs). Median follow-up was 4.3 years (IQR 3.0–6.0). Current drinking was reported by 36,030 (31%) individuals, and was associated with reduced myocardial infarction (hazard ratio [HR] 0.76 [95% CI 0.63–0.93]), but increased alcohol-related cancers (HR 1.51 [1.22–1.89]) and injury (HR 1.29 [1.04–1.61]). High intake was associated with increased mortality (HR 1.31 [1.04–1.66]). Compared with never drinkers, we identified significantly reduced hazards for the composite outcome for current drinkers in HICs and UMICs (HR 0.84 [0.77–0.92]), but not in LMICs and LICs, for which we identified no reductions in this outcome (HR 1.07 [0.95–1.21]; pinteraction<0.0001).